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THIS IS THE FIRST ISSUE OF VMQ, THE NEW QUARTERLY VERSION OF VIRGINIA MEDICAL. THE NEXT ISSUE WILL BE DATED OCTOBER 1990. THEREAFTER, ISSUES WILL GO INTO THE MAIL IN JANUARY (WINTER), APRIL (SPRING), JULY (SUMMER), AND OCTOBER (AUTUMN). ON PAGE 287 OF THIS ISSUE THE MEDICAL SOCIETY OF VIRGINIA'S PRESIDENT REVIEWS THE REASONS FOR THE CHANGE IN THE JOURNAL'S FREQUENCY. THE DIRECTORY OF VIRGINIA PHYSICIANS IS TO BE PUBLISHED SEPARATELY; AN ANNOUNCEMENT OF THE 1991 EDITION APPEARS ON THE BACK COVER OF THIS ISSUE.

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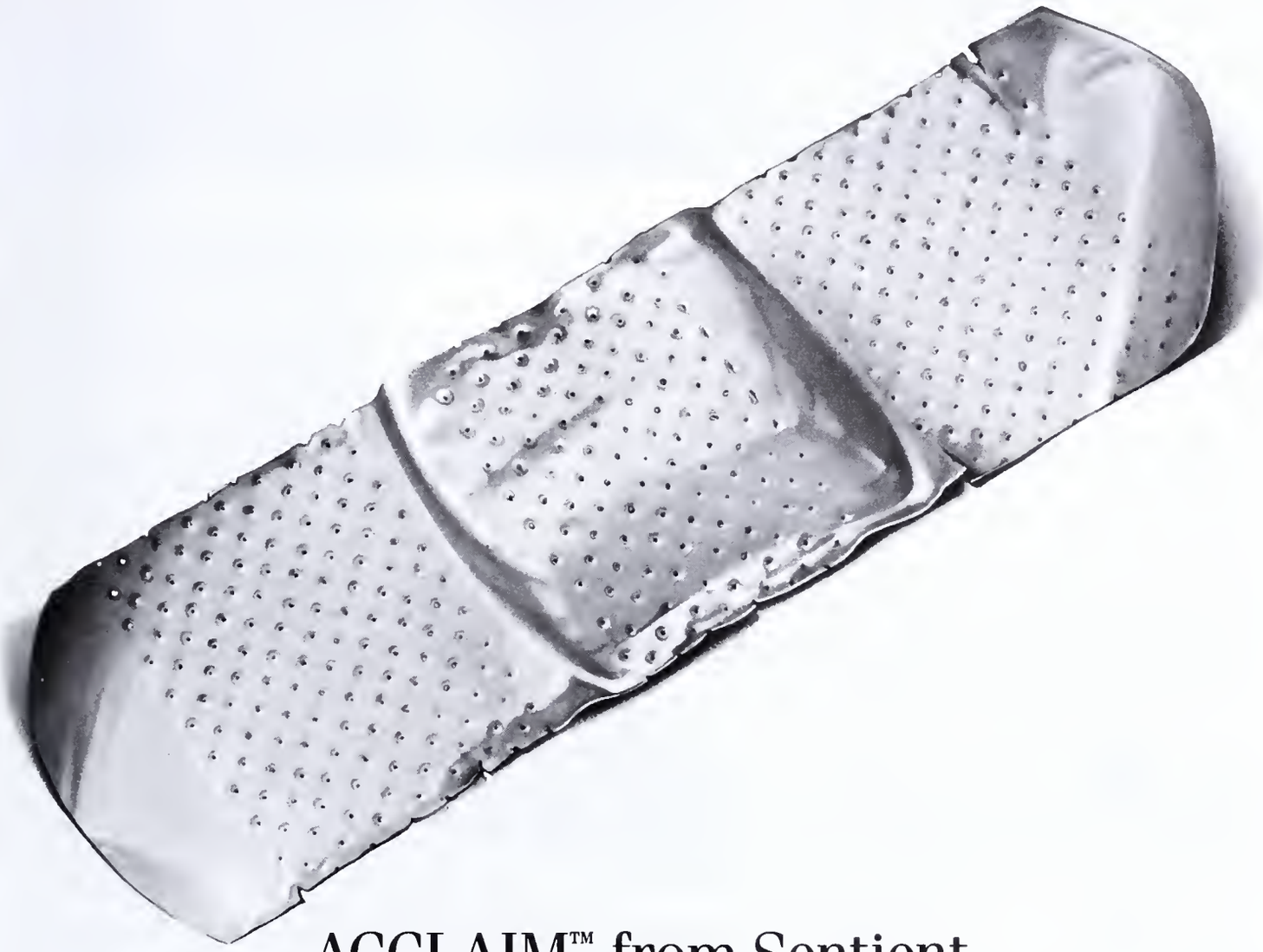

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LETTERS TO THE EDITOR

We welcome your Letters to the Editor.

All letters should be sent to the Editor, VIRGINIA MEDICAL QUARTERLY, 4205 Dover Road, Richmond VA 23221. Please include your name and telephone number. VMQ reserves the right to edit all letters.

Strongly favors privacy for hospital patients/staff

I refer to the Point of View commentary in the April issue in which the author laments the "total demise of hospital wards."[1]

Having been a student, intern and resident in the time of open wards (some in poor locations), I would put in a strong statement in favor of privacy for patients and staff in hospitals.

To equate economy-class airline space with wards in hospitals is spurious. Even economy might not apply to both. Certainly economy class by way of wards in hospitals should not be imposed. Furthermore, arriving at the same time on a plane, whatever the class, is a different matter from being treated and trying to recover on a ward.

Some people require privacy. For those who do not need or wish to have solitude, this is a foreign concept, impossible to explain on the one part or to understand on the other.

There remains a place in the world, medical and otherwise, for A Room of One's Own.

Maryjane Luke, MD

Box 351, Glencairn
Covington VA 24426

1. Monteo JM II. Point of View: The case for economy class. Va Med 1990;117:165

Dr. Montero replies: Sadly, the uninsured and underinsured segment of our population no longer has a choice of a less expensive room and, for that matter, ward. Isn't a choice of affordability the essence of our free enterprise system?

Spotlight on cord blood transplant reminds them of a Va Med first

Considerable recent attention has been given to the use of umbilical cord blood for bone marrow transplantation by the medical literature[1] as well as the lay press and television. This letter is written to address the fact that it was the VIRGINIA MEDICAL MONTHLY that published the original article on this usage in 1972[2] and raised the possibility of umbilical cord blood banks. The clinical work was performed in Petersburg, Virginia, and the laboratory studies in Atlanta, Georgia. The article reported a patient with acute lymphoblastic leukemia who obtained a documented temporary graft following administration of a relatively small quantity of umbilical cord blood matched only for ABO typing.

The use of umbilical cord blood and the potential for cord blood banking has met with considerable resistance. The original publication in 1972 has been largely ignored,[1,3] and even at Chernobyl it apparently was not considered, fetal liver cells instead being utilized

unsuccessfully when bone marrow was not available.[4] Following Chernobyl, we attempted to revive the concept that umbilical cord blood holds potentially equal or significantly greater capability for marrow transplantation than does human adult blood marrow, as reported in two more recent articles verifying this basic concept.[5,6]

Twenty years ago no untoward effects were noted in the 17 terminal patients to whom one of us had given umbilical cord blood late in the progress of their malignancies, including the patient with acute lymphoblastic leukemia mentioned above.[7]

When umbilical cord blood banks and the use of cord blood for marrow transplantation come into existence, the future of medical therapy will be significantly altered, and the article in this journal 18 years ago will, we believe, have led the way.

Norman Ende, MD

New Jersey School of Medicine
Newark NJ 07103

Milton Ende, MD

121 South Market Street
Petersburg VA 23803

1. Gluckman E, Broxmeyer H, Auerback AD et al. Hematopoietic reconstitution in a patient with Fanconi's anemia by means of umbilical cord blood from an HLA-identical sibling. N Engl J Med 1989;21:1174-1178
2. Ende M, Ende N. Hematopoietic transplantation by means of fetal (cord) blood—a new method. Va Med Mon 1972;99:276-280
3. Broxmeyer HE, Douglas GW, Hangoc G et al. Human umbilical cord blood as a potential source of transplantable hematopoietic stem-progenitor cells. Proc Natl Acad Sci USA 1989;86:3828-3832
4. Linnemann RE. Soviet medical response to the Chernobyl nuclear accident. JAMA 1987;258:637-643
5. Ende N, Rameshwar P, Ende M. Fetal cord blood's potential for bone marrow transplantation. Life Sci 1989; 44:1987-1990
6. Ende N, Giuliani D, Ende M, Ponzio NM. Production of human to mouse xenografts by umbilical cord blood. Life Sci 1990;46:1373-1380
7. Ende M. Lymphangiosarcoma: report of a case. Pac Med Surg 1966;74:80-82

Cites benefits of prescribing powers for nurse practitioners

What an irony it is that during the same month that VIRGINIA MEDICAL lamented editorially the unavailability of medical care for a significant number of Virginia citizens,[1] The Medical Society of Virginia actively discouraged the bill that would extend prescriptive authority to nurse practitioners, thereby contributing to its carryover.[2]

There are a significant number of Virginia citizens whom medical doctors cannot and will not serve. Some of these citizens might well be served by nurse practitioners, especially in the area of obstetric and

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gynecological care. One of the barriers nurse practitioners encounter in assuming some of this care is their lack of prescriptive authority.

Instead of opposing the extension of prescriptive authority to nurse practitioners, the Society should take the active step of encouraging it. This step would not hurt us. There are not enough nurse practitioners to have significant negative impact on the practices of most physicians in the state. In fact, supporting extension of prescriptive privileges would result in very favorable publicity. The public would see that we are interested in improving the care of patients and serving their best interests, and not strictly serving our own interests. The favorable publicity from this position might also help us in fighting other more noxious proposals, such as mandatory assignment and the extension of prescriptive authority to optometrists, pharmacists and chiropractors.

The Society has a chance to do something that would confound its critics and not hurt itself and be of great help to the medically underserved citizens of Virginia. It can do this by strongly endorsing and supporting the extension of prescriptive authority to nurse practitioners.

James W. Turner, Jr., MD

2942 Hunter Mill Road, #102B
Oakton VA 22124

1. Morey DAJ. Access: Will we nibble at the edges or bite the bullet? (point of view). Va Med 1990; 117:66-67
2. MSV Legislative Update. February 1990, p 2

More waste for the hauler: the ironic polybag

I read with interest your April article on waste disposal[1] while noticing the ironic use of a plastic wrapper for mailing.

One should never criticize without a better solution. Therefore, I refer you to the enclosed brown paper wrapper used to dispatch a recent issue of *The Scientific American*.

Donald S. Daniel, Jr., MD

3540 Floyd Avenue
Richmond VA 23221

1. Keene JH, Gray A. Waste disposal: How to handle the new regulations. Va Med 1990;117:144-147

Retirement salute backfires, wounding five

I read in the May issue of VIRGINIA MEDICAL that I have retired![1] I do wish someone had called me before this was printed in the magazine.

On October 8, 1989, the community of Boykins gave an Appreciation Day on my behalf, which was quite nice and I enjoyed very much until the local newspaper printed a large headline in error that it was a retirement party. This information was retracted in a later issue but apparently lives on.

I am actively engaged in my practice, working 60 or more hours a week and at the present time have not considered quitting or leaving the community without a physician. I would appreciate an acknowledgement that I am not retired because it has caused great confusion.

J. A. Naranjo, MD

PO Box 365
Boykins VA 23837

1. Who's Who: Retirements. Va Med 1990;117:196-199

The Editors greatly regret the published misinformation about Dr. Naranjo.

We apologize also to all concerned for identifying Dr. John P. Heatwole's son as Dr. Kenneth M. (for Martin) Heatwole, the Charlottesville pulmonary specialist, when in truth he is Dr. Kenneth M. (for Michael) Heatwole, the Mechanicsville family practitioner.

And we are distressed to hear from Dr. John M. Stirewalt that the biographical material we published about him was incomplete and partially incorrect. He sends a revised version, herewith printed in full:

A medical career spanning both private and public health ended last year when Dr. John M. Stirewalt of Waynesboro retired from Western State Hospital. He served his entire professional career in Virginia and was at Western State for 22 years.

Born in Harrisonburg, Dr. Stirewalt lived his childhood in New Market, Virginia, and completed high school in Harrisonburg. He attended the University of Virginia undergraduate and medical school (Class of 1951) and completed one year of ENT training at the University's hospital. He first served as staff physician for Woodrow Wilson Rehabilitation Center and later as chief of medical services, then changed to private practice in Waynesboro. Returning to state employment, he served as assistant director for the Augusta/Staunton/Nelson/Highland County Public Health District (1963-1966). At Western State, which he joined in 1966, Dr. Stirewalt filled both clinical and administrative posts. He served as chief of staff in the Medical Center. In 1971, Western State Hospital established a specialized Geriatrics Receiving Unit, which developed into a 500-bed certified psychogeriatric facility of the hospital. In July 1976 he became its director of medical services.

Since 1953 Dr. Stirewalt has been an active member of the Augusta Medical Society and delegate to The Medical Society of Virginia for 12 years. He was honored by election to serve as president of the Augusta/Highland Medical Society in 1981. As a member of the Western State Hospital medical staff, he was appointed to the teaching faculty of the University of Virginia School of Medicine, Department of Behavioral Medicine and Psychiatry, in 1981 and still serves in this capacity.

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William H. Barney, MD

New MSV Media Mix

With this issue the journal changes from the VIRGINIA MEDICAL MONTHLY to the VIRGINIA MEDICAL QUARTERLY (VMQ).

The reasons for this change were outlined by the Editor, Dr. Kendig, in his editorial in the June issue.[1] The two primary reasons are the escalating costs of the publication of the journal, together with the declining submission of scientific articles. I know that many of us regret that this change is being made, but the alternative was to discontinue the journal altogether, and I think that this change does provide some positive opportunities for better communications with our members.

The new VIRGINIA MEDICAL QUARTERLY is to be published in January (Winter), April (Spring), July (Summer), and October (Autumn) and will be similar in format to that published on a monthly basis. Some effort will be made to increase the number of features, particularly human interest stories as they involve various groups of physicians.

In each of the eight months that the journal is not published, the Medical Society of Virginia staff will provide a newsletter, which will be a four- to six-page publication and prepared in-house with minimal publication costs. This will provide a vehicle for officers and committees of the Medical Society of Virginia to communicate with our members on a more timely basis. The lead time required to get an item in the newsletter will be about a week, compared to about six weeks for the printed journal.

In the survey last year inquiring into issues about which MSV members are concerned, it was apparent that there had been a lack of communication between our leadership and our members, and this is an opportunity to correct that deficiency. All members of the Medical Society of Virginia are invited to avail themselves of the journal, as well as the newsletter, to publish timely articles and announcements which may be of interest to our members.

1. Kendig Eljr. Now a quarterly. Va Med 1990;117:265

The Capitol Connection

JOHN WARNER charged through the doorway and started politicking like a man who is 15 points down in the polls and needs every vote he can get. No matter that he is totally unopposed for reelection, the veteran senator worked the room for all he was worth, clasping hands, clapping backs, laughing, listening, laying on the eye-to-eye contact. It was a virtuoso performance. The doctors loved it, and Warner's peers from the House smiled indulgently.

The setting was the Medical Society of Virginia's annual Congressional Luncheon, with which the Society's leadership honors Virginia's legislators on Capitol Hill, staged this year on May 9 in the Gold Room of the Rayburn House Office Building. Twenty-seven MSV officers, councilors, and AMA delegates made the trip. All eight of Virginia's congressmen were there, sitting at lunch with the councilors from their districts, while Senators Warner and Robb flanked MSV President William H. Barney at the head table.

A week earlier, the Medical Society of Virginia Auxiliary had also connected with some high-ranking Washingtonians. For pictures of that event, turn to page 290.

Clockwise from top left, Senator Warner is shown with Rep. Frederick C. Boucher (seated) and Dr. James L. Patterson, Jr.; Dr. Richard L. Fields (back to camera); Dr. H. Alan Bigley, Jr.; Rep. L. F. Payne, Jr. (center), and Dr. Edwin J. Harvie, Jr.; Dr. William H. Barney (right), Dr. Louis D. Parham (foreground), and aide Rem Dickinson (behind Warner).

Photographs by Mark Charrette

Capitol Connection, Auxiliary Style

THE CELEBRITIES the Medical Society of Virginia Auxiliary fielded during its annual convention were Marilyn Tucker Quayle, wife of the Vice President, and Nancy Sununu, whose husband is White House chief of staff. In a jostle of Secret Service men, the two women arrived to speak at the Auxiliary's post-convention workshop on May 2 at a hotel in Washington's environs. Mrs. Victor N. Guerrero, newly elected MSVA President, ushered them into the room.

Mrs. Quayle dazzled. She has selected breast cancer as the focus of a personal campaign, and she spoke on behalf of education and detection. Mrs. Sununu encouraged, speaking in praise of good works. "Where would we be if all the volunteers in this country disappeared overnight?" she asked. Her audience of 130 volunteers knew the answer to that.

Then the two honored guests departed, and the Auxiliary members settled down to such mundane matters as new techniques for increasing membership and how to run a meeting.

Above, Heidi Guerrero (left) introducing Mrs. Quayle.
In the background, Dr. John A. Owen, Jr., MSV President Elect.
Below, Mrs. Sununu (left) and Mrs. Quayle at the microphone.

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WHO'S WHO

Dr. F. J. Pepper, Alexandria, is the new president of the Virginia Board of Medicine. His election culminates eight years of Board membership, including service as vice president and secretary-treasurer. A native of Omaha, Nebraska, Dr. Pepper was graduated from the University of Nebraska College of Medicine in Omaha (Class of 1965) and performed his residency in psychiatry at St. Elizabeth's Hospital in Washington DC.

Elected vice president was **Dr. Read F. McGehee, Jr.,** Richmond, whose specialty is pulmonary diseases. Tony C. Butera, Alexandria podiatrist, was reelected secretary-treasurer.

Dr. Owen W. Brodie, Jr., walked out of his office at Richmond's Westbrook Hospital late last year, motored to the airport, climbed into his single-engine Cessna Cardinal, and flew off into the blue October sky. Thus ended Dr. Brodie's 21 years of private psychiatric practice at Westbrook, and thus began his career with CompHealth, a national locum tenens firm, and his presidency of the Flying Physicians Association, both of which have kept him on the wing ever since.

"I've wanted to fly ever since I was a kid in Lynchburg, watching Piedmont's DC3s coming into Preston Glenn Airport," Dr. Brodie remembers, "and if I'd had good enough eyesight, I would have made a career of flying." Instead, he set his sights on medicine, graduating from the Medical College of Virginia in 1962 and taking a residency in psychiatry at Duke University. He established a private psychiatric practice at Westbrook Hospital in 1968, serving successively as director of its geriatric and adult intensive care programs and as president of the medical staff. He has been president also of the Southern Psychiatric Association and the Neuropsychiatric Society of Virginia and has contributed vigorously to an array of national, regional, and local medical societies, including the Medical Society of Virginia and the Richmond Academy of Medicine.

In 1972 Dr. Brodie started taking flying lessons, in 1974 he got his pilot's license, and in 1976 he earned his instruments rating. Most of the 1,055 members of the Flying Physicians Association which he now heads are licensed pilots, although that is not a requirement of membership. The Association's annual meeting this year is in Vancouver, Canada, and in August Dr. Brodie's Cessna will take him and his wife Pat there. Two other Virginians have been president of the Flying Physicians Association: **Dr. Paul A. Woods,** Waynesboro, and **Dr. Benjamin H. Word,** Charlottesville.

As for the locum tenens practice, "Pat and I love to see new places, meet new people," says Dr. Brodie, and they're having a grand time flying about the 50 states and doing just that.

President Brodie and wings.

Photo courtesy *The Flying Physician*

New president of the Norfolk Academy of Medicine is **Dr. Randolph J. Gould,** Norfolk surgeon.

For his "twin hallmarks of service, medicine and education," **Dr. William F. Bernart,** Nassawadox, was selected by the Eastern Shore Chamber of Commerce for its 1990 Outstanding Citizen of the Year award. Dr. Bernart has practiced on the Eastern Shore for 33 years, and has been active with numerous health fairs, the Northampton-Accomack Memorial Hospital's Auxiliary, and its School of Nursing. The father of five children, he has been a member of the Northampton County School Board, the Eastern Shore College Foundation, and Project Horizons, a group that identifies talented middle school children and seeks to insure that they are offered higher education.

As part of a White House program to encourage volunteerism, President George Bush has honored a Richmond pediatrician who volunteers some 30 hours a week as medical director of the Richmond Cere-

bral Palsy Center. He is **Dr. Gayle G. Arnold,** who was selected as a "Point of Light," the 114th chosen since the program was launched. In private practice in Richmond since 1951, Dr. Arnold is president of the American Academy of Cerebral Palsy/Developmental Medicine.

New president of the Psychiatric Society of Virginia is **Dr. John O. Hurt, Jr.,** Salem.

Dr. John M. Daniel III, Richmond, has been elected president of the Virginia Society of Internal Medicine.

Honorary degrees were conferred on four persons at the College of William and Mary's commencement exercises in mid-May, and **Dr. Janet Kimbrough** of Williamsburg was one of them. The 88-year-old retired physician received a doctorate of humane letters. Dr. Kimbrough was the sixth generation of her family—descendants of St. George Tucker, a W&M student in the 1770s and the college's second professor of law in 1790—to attend the college, graduating Phi Beta Kappa in 1921. The other honorees were Virginia's Gov. L. Douglas Wilder, Sir Antony Acland, British ambassador to this country, and D. Tennant Bryan, chairman of Media General.

Last year he won the National Interscholastic Athletic Administrators Association's Distinguished Service Award (Va Med March 1990). This year **Dr. H. Joseph Williams**, Staunton, was named 1990 Rotarian of the Year by Staunton's Rotary Club for being "an outstanding role model for others in the community and in the Rotary Club." Dr. Williams retired recently after 40 years as team physician for the football and basketball teams of Robert E. Lee High School in Staunton.

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Life With Managed Care, A Cautionary Tale

Managed care plans definitely need you, but you may or may not need them, warns the author, who advises plenty of research before signing on the dotted line.

The last 15 years have been a real learning experience. I'm in a ten-person family group practice, all Board certified. Our training and experience is just that—practicing family medicine. That's what we have all wanted to do—and hope to continue. We are old and young, with ages spanning from 30 to 60.

Ten years ago we were a five-person practice, and ran a family practice training program. Then Managed Care came to town. Up to then insurance was pretty simple: file for indemnity insurance and bill the patient what insurance didn't pay. If there was a problem, the patient took it up with his company. Sounds cool. Of course we could add Medicare. Accept it or not, it didn't seem to make much difference, so we accepted it. And add Medicaid: We were already doing our share of free medicine so why not sign up for Medicaid and get paid a little? No problem.

I'd read somewhere that we were in a "targeted" area for managed care plans. Other than being a little curious, I went on to the sports page.

Here they came.

Plan A.

An HMO, owned and run by a big corporation.

"All you have to do is sign up" and "we'll deliver you bunches of patients" and checks every month, guaranteed, based on a "capitation rate."

We met as a group and discussed it. The smarter ones in the group (not me) admitted they didn't really understand all the implications and would rather take a wait-and-see approach. We not-so-smarts prevailed, stating we could learn by being part of it. So we joined.

Plan B.

An HMO owned by physicians.

Even better than Plan A because you'll not only make money practicing medicine, you'll make money on "the plan" by being an owner. Of course you'll have to put up a few

by John A. Mapp, MD

thousand to get it going. And, listen to this, they had better cap rates than Plan A, and higher co-pays to reduce patient abuse. We met as a group and this time even the smarter ones were lured by the thought of being an owner, making money both ways. We joined.

Plan C.

Here's a nifty twist. It's an HMO, but the HMO does its annual cap rate to an IPA. You join the IPA and the IPA then does business with you on a discounted fee-for-service basis.

"Well, what would we be joining" we asked, "an HMO or a PPO?"

"Well, it's kind of both," and "with the advantages of each," came the reply. We met. We joined.

Plan D.

Forget the description. We met. We joined.

Plan E.

We joined.

Plan F.

Guess what, we didn't join! It might have been a good plan or a terrible one. It didn't really matter because by then we were entirely too confused and tired just trying to sort out the tangle of the ones we were in.

Why?

What brought these on? We were so comfortable before. The answer is both simple and complex. The spiraling cost of medicine is the simple answer, and it's true. Any insurance plan has to keep up with costs by raising the premium. Raising the premium hurts after a while, both the individual and the employer who's paying a part of the premium. Especially if the premiums *double* two years in a row.

The complex answer lies in the why's of the spiraling cost increases, and I won't get into all of this. The costs of rapid technological changes and improvements; hospitals charging on a cost plus basis; unusual but true cases of physician overcharges; labor costs; medical malpractice premiums. It all adds up to *expensive*. So much so that a large segment of our population doesn't have *any* medical insurance. Too poor to pay the premium and too rich to be eligible for Medicaid.

So what happened?

We learned, bit by bit. Plan A was rolling along. Our committee met with their committee, and we made some adjustments and they made some adjustments.

Read a "hold harmless" clause some time. It should be simple. The "plan" should not be responsible for your goofs and physicians should not be responsible for theirs. That's it. On one occasion we had two lawyers (ours and theirs) arguing over the interpretation of the legalese written into the hold-harmless clause. We finally got it simplified.

Then something happened with Plan A. Committees' recommendations started falling on deaf ears, and "corporate decisions" came in the mail. The crowning blow came when our "withhold" percentage went up. It not only went up, it went up *retroactively*. They actually sent us a bill. What a learning process; and in the fine print they had us. Well, we got mad, and we got out. And we wrote our patients and told them why. It hurt for a while, but 95% of those patients are back with us under another plan. Other physicians' practices left Plan A also, and Plan A is not much of a player in our service area any more.

"Withholds" are a particular irritant to us. If the plan makes money we're supposed to get a good percentage of the "surplus" back. It's a financial incentive to prevent us from "over-testing" and "over-re-

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ferring." It's also an incentive to "under-test" and "under-refer." We call it a conflict of interests.

Many plans come into an area knowing they're going to lose money overall for three to five years. It's their "loss leader" to get into a particular area, but they still play the withhold game with physicians. We finally came to grips with this by treating withholds as extra discounts and then deciding if we can make a fair profit with that particular plan. That way we practice medicine the way we want and according to what we think is best for the patient.

Plan B. Remember, that's the physician-owned one. It was rolling along okay, too, for a while. Being physician-owned, we had more input and even had a physician director. We made adjustments—lower withholds, better cap rates, differential co-pays according to office hours, after hours "urgent" situations, etc. Only one problem, Plan B lost money and we owned it. And we (about 150 physicians) didn't have the deep pocket to carry it through. A good-sized corporation eventually bought it and then an even larger one bought it again. It's still around, but not with our physician director or our committee input. I hear it's still losing money.

We did solve a problem regarding co-pays with this plan. Can you imagine the potential for patient abuse of a plan with a $3 co-pay for anything, regardless of urgency or appointment, or of time of day, night, weekend, or holiday? One patient, I'll call him Bill, used to come in rather regularly on Mondays for his "flu" and to get his work "sick slip." Definitely worth $3 to have Mondays off. Bill had outsmarted the plan.

Our variable co-pay according to appointment, no appointment, urgency, time of day, weekend, etc., finally straightened this kind of abuse out. Of course, 95% of patients don't abuse plans. They simply want good medical care without paying a fortune in premiums.

Plan C. Remember the one that's kind of an HMO and kind of a PPO? It's still rolling along, but guess what? Some time ago they said that they may raise the withholds for "certain physicians." But this time we've told them up front that we'll get out if they do that to us. So far nothing has happened.

The point here is that you, as a practice, *can* have some influence on these large corporate decisions. If it's a managed care plan, they need quality primary care physicians. You also have a lot of influence with your patients and their employers when they're looking at these different plans.

Conclusion.

If you read somewhere that your area is targeted for managed care plans, take the time to learn something about them. And don't hesitate to get some consultation. Physician management consultants can help. So can physicians who have been directors or medical directors of some plans.

These plans definitely need you, but you may or may not need them.

Plans for Those Without a Prayer

The under-insured, uninsured, and those otherwise disenfranchised medically—their ranks are growing, and they haven't a prayer of paying the price of admission to an HMO, a PPO, or any other of the managed care plans Dr. John A. Mapp talks about in his cautionary tale above. Dr. Mapp believes this situation must change, and he believes physicians must be "on the front end of the change, rather than just reacting to changes others have made." He urges physician support for the recommendations of his specialty society, the American Academy of Family Physicians; under these recommendations, all Americans not otherwise covered could be insured and have access to a broad range of essential health care services. For a copy of the AAFP Position Statement spelling out the particulars, write to the Virginia Academy of Family Physicians, 4211 Dover Road, Richmond VA 23221.

The three major components of the AAFP's recommendations are Medicare, employer-provider coverage, and a restructured Medicaid program. These access routes are key also to the American Medical Association's Health Access America program, which was unveiled in Washington earlier this year. The Medical Society of Virginia has endorsed this program and at the 1990 session of the General Assembly lobbied successfully for the passage of legislation dealing with Medicaid reform, basic coverage policies for certain small employers/groups, and research into mandated insurance benefits with a view to limitation. MSV President William H. Barney has said that the Society's legislative committees and Council will continue to work for implementation of the total AMA access package. —A.G.

Caveat Signator: Evaluating the Fine Print

Does the contract offer you a fair exchange for the fees, time, flexibility you give up? An affiliation tilted toward the managed care plan could do your practice more harm than good.

by Geoffrey Anders, JD, CPA

An increasing number of doctors are choosing to participate in Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other managed care plans.

There are some good reasons for doctors to affiliate with managed care operations. In the right circumstances, they can provide your practice with an increased patient base and a steady flow of income. Yet participation with managed care plans is not right for every practice; and though one managed care plan is right for you, another may not be.

Business Considerations

Sometimes it is difficult to withstand the pressure, real or imagined, to join a managed care system. Hospitals often urge doctors to participate as a way of bolstering admissions. Specialists are concerned that non-participation may result in fewer or no referrals from participating primary physicians. Some managed care plans will themselves use tough tactics to get doctors to sign up, for example, threatening that the opportunity is "now or never." Usually, however, the pressure passes and the competitive fears are shown to be overblown. Few medical communities are so dominated by just one or two managed care programs that they preclude lucrative private practice, or the introduction of competing plans.

Participating with managed care plans should involve trade-offs, though too often doctors give discounts or accept capitation risk with only vague promises of patient volume in exchange. You should compare carefully the concrete opportunities being offered with what the plan asks you to give, e.g., fee discounts or unlimited services. Test those opportunities against your practice's goals and characteristics. Do you really need this plan? What will you gain compared to what you lose?

Look at the plan's actual subscriber base—does it give you access to a patient group that you would like to serve? If you are offering a reduced fee, will the plan guarantee you at least a minimum patient volume? Or can the discount be placed on a sliding scale, tied to volume?

Remember, too, you do not want to let any one plan become too large a share of your practice base. Fifteen percent is a good benchmark, beyond which you should move only carefully. When one plan controls too large a portion of your patient base, its decisions and financial well-being can affect your practice negatively.

The Contract

Once you have made a strategic decision to participate with a managed care plan, your attention must turn to the rules that will guide your participation: the contract. Each organization will develop a contract

Geoffrey Anders is president of The Health Care Group, Inc., a practice management consulting firm. Address reprint requests to him at 140 West Germantown Pike, Suite 200, Plymouth Meeting, Pennsylvania 19462. Multicopy requests for distribution to groups will be honored. © 1990.

designed to meet its individual goals; therefore, while the broad outlines of managed care contracts are similar, you cannot assume the details will be, too. An arrangement that looks quite beneficial to you on the surface can turn into a liability when you dig into the contractual obligations.

A contract is a legally binding agreement. Do not sign it unless you understand and accept both the rights and responsibilities created. Feel free to negotiate a key point with a plan. And remember, once an agreement is signed, the law will not release you from its terms because the contract proves to be disadvantageous.

Because managed care contracts can be quite different from other types of contracts a doctor comes into contact with, it is important to understand their subtleties. Here is a review of some key points about managed care contracts and some key questions to ask either yourself or the plan's representative. Keep in mind that this is a general overview. If you are considering signing a managed care contract you should have an experienced attorney review it in detail.

General Contractual Issues

Quite often a managed care plan will retain the right to amend the contract, without giving you a similar privilege. Determine if a contract can be amended by the plan, and how quickly you can get out if the amendment is not to your advantage. Does the required notice for your terminating the agreement mesh well with the notice you receive of a change in the plan's terms? In any event, having to wait longer than 90 days to terminate your participation with a plan, for whatever reason, will not serve your interests. In general, try to avoid a situation where the plan may make unilateral changes in the contract. Especially, do not allow the plan to change unilaterally the services you must provide.

Managed care contracts do not always contain all the pertinent information that affects you. If a contract refers to an "Operations Manual" or to other documents, review them before signing the contract. Make sure you understand the plan's options in amending the manual; frequently, a contract cannot be amended without your approval, while a manual can. This means you could have little recourse when a manual change affects you negatively.

Vague language in a contract can come back to haunt you, e.g., "in a timely manner" or "general administrative duties." Whenever possible, have such language removed or clearly defined.

Most plans will not let you assign your contractual responsibilities; therefore, you should have the option to leave the contract if the plan chooses to assign its part.

Many contracts warrant the quality of medical care to be provided. This vague provision serves no good purpose, except that it may allow a plan to sue you in a contract action if you or they are hit with a malpractice suit. Such a provision should be struck from the contract.

Plans will often want the use of your name for promoting its services; you should have the same right, and the contract should provide for mutual use of names for promoting services.

Capitation and Fees

For primary care specialists, a standard arrangement in many plans is for it to pay you a set fee for each patient who designates you as the primary physician. This "capitation fee' is the same whether a patient needs care once a week or once a year. You should determine if the capitation fee offered you is a fair one. To do this, take a sample of your own patient base—one that is demographically similar to the plan's patient base—and review the services you provided them in the last year or more; based on that information, get a ball-park figure on how you would fare if the capitation fee were applied to your existing patients.

Patients with pre-existing conditions may skew the actuarial assumptions underlying your capitation payments—and so could cost you a great deal of money. While the plan must accept these patients, determine if the contract provides concessions to you for treating them.

Be sure the contract includes a process for regular increases or recomputation of fees. It is important that these be tied to some objective outside scale, e.g., Medicare fees or a medical cost index, rather than simply left open to negotiation.

Billing

One "benefit" often touted by managed care plans is the ease of billing functions: reduced paperwork, no bad debt risk and no collection efforts needed. But this benefit can be illusory. In fact, you may find that your regular billing activities are simply shifted from post-service, when you bill your own patients, to pre-service—where your staff must ascertain patient eligibility, receive authorizations, or obtain precertifications. You must be sure that these business activities can be handled efficiently within your current operations; if not, do the changes necessary to take on the plan's requirements constitute a worthwhile investment for you?

There are other questions to ask about the billing process. Examine the claims-submission routine to determine if it is reasonable, and if it will mesh with your billing processes. Review the time limit for submitting your claims to the plan. A 30- or 60-day period is too short; look for a period of six to 12 months.

Find out how long the plan may take to make payments: Can you live with that? Will the plan pay you interest if payment turn-around exceeds the agreed time period? If the plan goes into default, will you still be required to see patients? And if so, for how long, and what remedy is available to you?

What happens if you deliver medically necessary but "non-covered" services: May the patient be billed and under what circumstances? And

if the patient demands services that are not covered or approved by the plan, may you bill the patient directly?

Services

Make sure you can provide each service required by the contract. If not, are you expected to arrange for those services to be provided? Can those services be subcontracted? Should the contract require it, are you willing to expand your services or facilities to provide the full range of services described?

Coverage

What coverage procedures are acceptable? If your current coverage doctors are not also plan participants, will they be reimbursed for their services by the plan?

Referrals

What happens if you need to refer outside the plan? Are there set procedures for approvals and reimbursements? Are you comfortable with the plan physicians to whom you likely would be required to refer?

Utilization Review

Occasionally, managed care contracts obligate you to serve in the plan's utilization review process. Determine the nature and frequency of those responsibilities—and if you really want to be involved in that process. If you will be serving, you should be indemnified by the plan against liability arising from your utilization review activities.

Be certain that you understand the utilization review process and determine if you find it a reasonable one. Is there formal education on the plan's utilization requirements? How are over-utilization issues handled: Are there provisions for negotiations and arbitration? Is there a "rehabilitation" routine or might you be "cut off" summarily? And how are medical necessity disputes handled?

Risk Pools and Holdbacks

Many plans will withhold a portion of the capitation fee to create a risk pool, as insurance against greater-than-expected expenses. If those dollars are not needed to cover unexpected costs, they are shared with you. Several points about the risk pool holdback should be made clear in the contract: How is your contribution returned and when? Are you obligated to cover any deficit in the risk pool? If you terminate plan participation, do you still benefit from risk pool distributions for the period of your involvement?

Find out who else is included in your risk pool. Be sure you are comfortable with their practice style and with being financially tied to these persons.

Liability

In the past, plans often included an indemnification, or "Hold Harmless" clause, stating that the doctor was responsible for the costs from suit or claim in which the plan was involved. Today these clauses are usually found in watered down form, although you should still negotiate them out of the contract.

Be sure to send a copy of any indemnity or hold harmless language to your insurer. Insurers will not cover contractually assumed liability, and you will want written assurance from your malpractice carrier that you will be covered under the specific language of the plan's contract.

If your practice is incorporated, it—not an individual doctor—should be making the agreement with the plan. Therefore, sign the contract as a corporate representative, not on your personal behalf.

Protecting Your Future

Check the managed care plan's history in other parts of the country. You should know if there have been any serious problems between the plan and its doctors. It is especially important to know if the plan has a history of operating a staff or group model—employing its own doctors, rather than contracting with existing practices. If this is the case, the plan could simply be using you to get itself up and running, planning to take away your patient flow and direct it in-house later.

To protect yourself, negotiate into the agreement a provision that the plan will not provide direct services during the term of your contract—and for one or two years after your agreement ends.

Retain your right to accept or reject an individual new patient; you may not want to handle a patient who has a history of non-compliance or of being litigious.

Medical Records

If the contract authorizes the plan to have access to the patients' records, what provision is made for your legal and ethical responsibilities regarding confidentiality? And if you are required to transmit patient records to the plan or another provider, who pays the expense?

Conclusion

It is essential for you to understand fully what you are obligating yourself to when signing a managed care contract. The plan may not make it easy for you; your obligations may be spread throughout the document—or through several documents in addition to the contract—and may be implied rather than given explicitly. Allowing an experienced attorney to review the contract is a wise course of action.

You must also consider the effects that a managed care plan's operating scheme may have on your practice's existing routines. Gaining plan patients may not be worth the effort to make over your practice's billing, scheduling and coverage procedures. A practice management consultant can give you a detailed picture of how a managed care affiliation will affect your business routines.

Finally, in evaluating a managed care contract, you must determine if you are getting a fair exchange for the fees, time, or flexibility you may be giving up. In the long run, an affiliation tilted toward the managed care plan could do your practice more harm than good.

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Ruptured Abdominal Aortic Aneurysm: The Case for Elective Resection

Roger T. Gregory, MD,
Pyong Yoon, MD, Jock R. Wheeler, MD,
Stanley O. Snyder, Jr., MD, and
Robert G. Gayle, MD,
Norfolk, Virginia

ABDOMINAL aortic aneurysms (AAA) represent a relatively common finding in the general population, occurring in nearly 2% of consecutive postmortem examinations.[1] With an expanding senior citizenry, more attention should be directed to appropriate diagnosis and management of this degenerative complication of arteriosclerosis.

The term aneurysm is derived from the Greek "aneuryneim," meaning to widen or dilate. Once widening or dilatation of the aorta begins, the natural history of AAA is that of progressive dilatation leading ultimately to rupture.[2]

DuBost reported the first successful elective resection of an AAA in 1952.[3] In 1953, Cooley and DeBakey reported repair of a ruptured AAA, a situation which previously had been universally fatal.[4] Data reported by Estes in 1950 allowed comparative analysis by Crawford and others to define the positive impact of AAA repair on actuarial tables in the ensuing decades, documenting continued progress in the treatment of abdominal aortic aneurysms.[5,9]

The diagnosis of AAA usually can be made by physical examination. In more than 80% of cases,[3] a pulsatile periumbilical mass can be palpated.[2] The characteristic calcified rim outlining the aneurysm wall on IVP, plain abdominal, or back x-ray often locate heretofore unexpected AAA. Once suspected, more precise diagnostic definition of the aneurysm as well as accurate measurements can be obtained by scanning techniques such as ultrasound or CT scan. Angiography provides additional data when precise adjacent anatomical information is needed for surgical planning.

The clinical presentation of AAA follows no set pattern. Patients may complain of nonspecific abdominal, flank or back discomfort. Occasionally, gastrointestinal bleeding may occur due to aortoenteric fistula formation. Rarely, ureteral obstruction is encountered. Distal emboli secondary to fragmentation of luminal debris occurs, but rarely. Sudden thrombosis of AAA is described, which may be dramatic in presentation, but fortunately is unusual.

The relationship between size of AAA, symptoms and rupture deserves careful consideration. Szilagyi suggested that size of AAA and likelihood of rupture were related, and that AAA 6 cm or larger merited repair.[6] Darling reported an autopsy series of patients with ruptured AAA and noted that a full 20% had AAA that were 4 cm or less.[7] Thus a "small" aneurysm is not necessarily a safe aneurysm. Citing the natural history of AAA, Crawford has suggested consideration for repair as soon as the diagnosis of AAA is made regardless of size, unless severely compromised cardiopulmonary status or imminent death from malignant disease makes this approach unrealistic.[9]

Rupture of an AAA is a well-known catastrophe. The diagnosis is suspected by the triad of abdominal or back pain, a pulsatile abdominal mass, and shock. Although without surgery the mortality approaches 100%, the results with surgical intervention have been disappointing in most series.[14] To define the treatment experience with ruptured AAA in the Norfolk area, a retrospective review was undertaken with particular attention to possible prognostic factors.

Materials and Methods

For the 13-year period 1975-1987, 81 patients operated on for ruptured AAA were identified. Seventy-one charts were available with adequate information for retrospective review. Thirty-three variables were reviewed as possible prognostic indicators, divided into seven categories, and submitted to multivariant analysis (Table 1). Cases were divided into two arbitrary time groups (Group I January 1975-June 1981; Group II July 1981-December 1987) for comparative purposes (Table 2).

Table 1. Prognostic Variables in 71 Patients with Ruptured Abdominal Aortic Aneurysms (35-92 yrs, mean age 70.3; 81.7% males; 88.7% Caucasians).

1. General: age*, sex, race, date of operation
2. Past Medical History: ASHD, CVA*, PVD*, DM, COPD, previous knowledge AAA
3. Presentation: pain, mass*, syncope*, systolic BP, arrest, shock*
4. Delay: onset of symptoms to ER*, ER to OR*
5. Intraoperative: OR time*, time of day*, extent of rupture, blood loss*, tranfusions*
6. Perioperative Complications: respiratory insufficiency*, pneumonia, ARDS*, MI*, arrhythmia*, hemorrhage, coagulopathy*, renal failure, sepsis*
7. Hospital Stay: extended*

* = statistically significant

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Table 2. Mortality in 71 Patients with Ruptured Abdominal Aortic Aneurysms.

Date	Patients	Deaths	Mortality
Period I: Jan 75-June 81	23	12	52%
Period II: July 81-Dec 87	48	24	50%
Total, 1975-1981	71	36	50.7%
Group I: 1976-1981	188		6%
Group II: 1984-1986	172	5	2.9%

Results

Caucasian males in their 70s were the most common patient profile (Table 1).

Multivariant statistical analysis with stepwise regression of the 33 variables showed that 20 were significant (p value of 0.05, Table 1). None of the variables were significant in the general category except age.

In the past medical history category (PMH), only cerebrovascular accident (CVA) and peripheral vascular disease (PVD) were significant. Urgency prevented a detailed PMH, which may have made this category incomplete.

In the mode of presentation category, mass, syncope and shock were significant, whereas pain was not. Range of blood pressure was not significant.

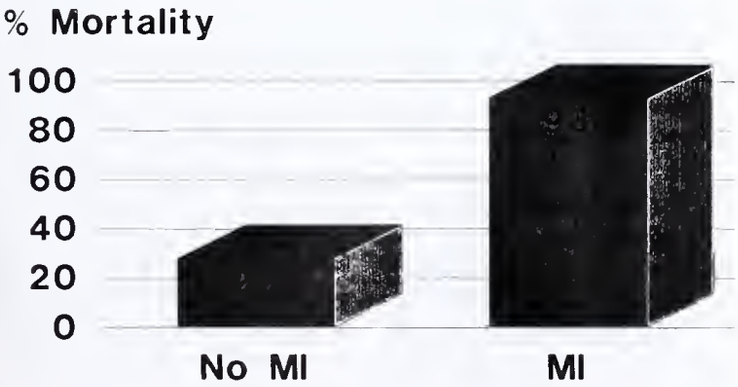
In the delay category, both delay from onset of symptoms to emergency room presentation and delay from emergency room arrival to arrival in the operating room were significant.

In the intraoperative category, blood loss and number of transfusions were significant as well as duration of operation and time of day (day vs night). Extent of rupture (free peritoneal vs confined to retroperitoneum) was not significant.

In the postoperative complication category, respiratory insufficiency, ARDS, MI, arrhythmia, coagulopathy, and sepsis were significant as well as extended hospitalization and renal failure. Particularly impressive was perioperative myocardial infarction, which carried a 93% mortality (Fig. 1).

Mortality for the earlier half of the study (Period I) was essentially the same as the later half (Period II), 52% vs 50%, with a combined mortality of 50.7% (Table 2). To compare this to elective cases, two separate patient groups were reviewed. Group I (1976-1981), consisting of 188 patients, underwent elective aortic aneurysmectomy with a 6% mortality (Table 2). Concerned by this mortality, a protocol to maximize cardiopulmonary and general medical status was instituted for patients undergoing aortic surgery including use of intraoperative Swan-Ganz catheters in all patients, overnight preoperative monitoring in selected cases, and preoperative cardiac assessment via isotope scanning (persantine—thallium) with selective cardiac catheterization and coronary bypass surgery where appropriate. Group II patients (1984-1986; 172 patients), consisting of those patients prepared by this protocol, were found to have a 2.9% mortality following aortic surgery with no deaths for those done through the retroperitoneal approach.[9] Although Group II patients represented a mixed group of patients with both abdominal aortic aneurysm and aortoiliac occlusive disease, the operative procedures and perioperative hemodynamics are basically comparable.[9]

Fig. 1. Influence of Perioperative Myocardial Infarction on Mortality in Patients with AAA.



Discussion

Mortality figures for patients operated on for ruptured AAA are high in most reported series. A survey of representative series of ruptured AAA over the past 25 years defines a mortality ranging from 37% to 65% (Table 3).[9-15] The mortality for patients seen in the Norfolk area shows a similar survival pattern and also shows that the mortality has changed very little over the past 13 years, remaining in the 50% range.

Table 3. Comparison of AAA Mortality in Seven Reports 1964-1989.

Series	Deaths/Total	Mortality
Hume et al 1964[15]	10/27	37%
Shumaker et al 1973[11]	87/158	55.1%
Hildebrand et al 1975[10]	67/131	51.5%
Ottinger 1975[13]	58/100	58%
Chidichimo et al 1982[12]	28/65	43%
Moore et al 1984[14]	29/45	65%
Gregory et al 1989[9]	36/71	50.7%

Careful analysis of multiple possible prognostic variables impacting on survival suggest that both the severity and duration of preoperative cardiovascular collapse had a significant effect on the outcome in this elderly group of patients. Furthermore, intraoperative factors have an additional devastating effect on these already compromised patients, leading to postoperative complications which frequently have a fatal result. Areas of possible beneficial change are difficult to identify and are clearly speculative, except to direct efforts towards control of hemorrhage and to minimize time in both the emergency room and the operating room.

In contrast to these disturbing mortality figures associated with ruptured AAA, mortality from elective aortic surgery fell dramatically during this same time

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period by carefully assessing and maximizing cardiopulmonary factors preoperatively, as well as employing a more consistent monitoring program in the perioperative period.

In comparing the results of surgery for ruptured AAA, which have remained at 50% mortality for the past 13 years, versus the mortality for elective aortic surgery, which has fallen to 2.9% over the same time frame, the conclusion is obvious. Every possible effort should be made to identify patients with AAA, consider elective repair, and avoid the emergency of rupture AAA and the attendant 50% surgical mortality.

Assistance in statistical analysis by C. Philpott, PhD, and editorial assistance by E.K. Greogry is greatfully acknowledged.

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ATLL Complicated by Strongyloidiasis and Isosporiasis: Case Report

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W. A. Petri, MD, M. E. Williams, MD,
and Charles E. Hess, MD,
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We present a patient of Japanese origin whose persistent gastrointestinal symptoms were initially diagnosed as indicative of strongyloidiasis, but whose subsequent course led to the diagnosis of HTLV-I-associated adult T-cell leukemia/lymphoma (ATLL). Although the association of HTLV-I and *Strongyloides* infection has been well described, this to our knowledge is the first reported case of both isosporiasis and strongyloidiasis complicating ATLL.

Case Report

A 52-year-old Japanese female without significant past medical history presented with complaints of mild epigastric pain, anorexia, weight loss, and diarrhea in July, 1987. Evaluation of the patient's stool revealed infection with *Strongyloides stercoralis,* and thiabendazole therapy was initiated. Despite adequate therapy for strongyloidiasis, the patient continued to have vague abdominal discomfort, mild nausea, occasional episodes of loose stools, and lost 20% of her total body weight within three weeks. She was admitted to her local hospital for parenteral nutrition and diagnostic studies. Ultrasound and CT scans of the abdomen and pelvis were unremarkable. Colonoscopy and air contrast barium enema revealed many superficial ulcerations in the rectosigmoid, with the remainder of the colon and terminal ileum being normal. Biopsy of the colon was consistent with a nonspecific colitis. The patient was discharged after a significant weight gain and clinical improvement.

Three weeks after discharge the patient was seen with complaints of ear pain, dry mouth, dysgeusia, and dysosmia. Physical exam at this time revealed several firm submandibular lymph nodes and biopsy of a minor salivary gland reportedly showed an atypical lymphocytic infiltrate. The patient was again having abdominal discomfort and anorexia and was readmitted for further evaluation in October, 1987. Physical examination revealed a cachectic, ill-appearing woman with bibasilar rales on lung exam, hepatomegaly, and diffuse lymphadenopathy. Significant laboratory data included SGOT 70 U/I (nl 5-35 U/I), LDH 1529 U/I (nl 297-537 U/I), alkaline phosphatase 521 U/I (nl 43-122U/I) and albumin 1.9 gm/dl (nl 3.0-5.2). CBC and other chemistries were within normal limits. Stool examinations for ova and parasites were negative at this time.

Extensive evaluation included repeat abdominal ultrasound and CT scan which showed ascites, intrahepatic and extrahepatic ductal dilatation, hepatomegaly and enlarged retroperitoneal nodes. A chest CT scan showed multiple, superior mediastinal and axillary nodes, a small pericardial effusion, and bilateral pleural effusions. Bone marrow biopsy was reported as normocellular. Lip biopsy revealed an atypical lymphoid infiltrate. Percutaneous biopsy of the liver showed a mixed portal cell infiltration suggestive of acute and chronic cholangitis with a focus of atypical cells. Thoracentesis gave evidence of atypical lymphocytes. Periaortic lymph node biopsy also demonstrated a polymorphous lymphocytic infiltrate.

One week after admission, a follow-up stool examination revealed *Strongyloides* larvae. The patient was once again treated with thiabendazole and parenteral nutrition. She developed fever and clinical deterioration two weeks into her hospital stay. Cultures of blood, urine and pleural fluid were negative. Laboratory data at this time included WBC 150,000/mm^3 (28% segmented neutrophils, 51% lymphocytes, 15% immature cells and 1 nucleated RBC), hematocrit 42%, platelets 217,000/mm^3, alkaline phosphatase 536 U/I, LDH 5459 U/I, and calcium 12.4 mg/dl. Peripheral blood smear was thought to exhibit a leukemoid reaction with bizarre monocytoid cells. Repeat bone marrow biopsy revealed a slightly hypercellular marrow with polymorphous lymphocytic infiltrates and nuclear atypia.

The patient was then transferred to the University of Virginia Hospital late October 1987. On presentation, she was an anxious woman in moderate respiratory distress. Vital signs included a temperature of 38.8°C, a blood pressure of 100/60, a pulse of 140, and labored respirations of 30 per minute. Her skin was clear. Mucous membranes were dry. Her neck was supple with marked jugular venous distention. Enlarged cervical, submandibular, axillary, and inguinal lymph nodes were present. Diffuse ronchi were heard with diminished breath sounds at both bases. Cardiac examination was remarkable for an S3 gallop. Abdominal

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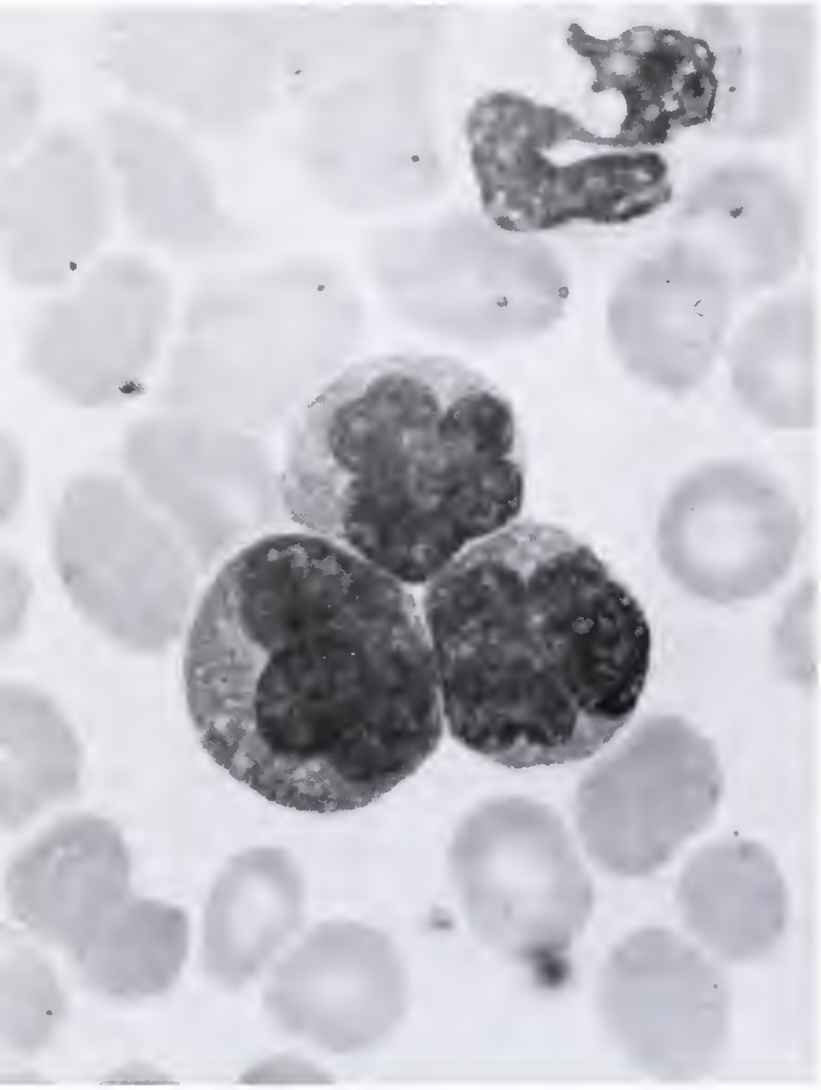

Fig. 1. Peripheral blood smear in patient with HTLV-I-associated adult T-cell lymphoma demonstrating characteristic lymphocytes with multilobulated nuclei (1250x).

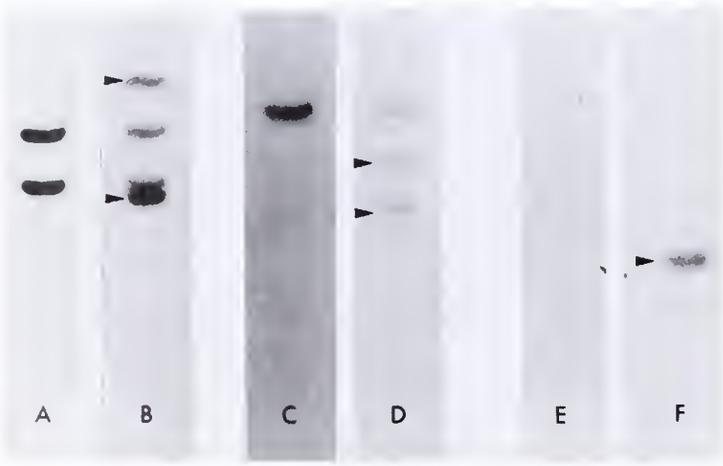

Fig. 2. Southern blot autoradiogram of control DNA (lanes A,C); HTLV-I negative T-cell lymphoma DNA (lane E); and patient DNA (lanes B,D,F). Probes included the T cell receptor gamma chain joining genes (lanes A,B); beta chain constant gene (lanes C,D); and the polymerase gene of HTLV-I (lanes E,F). Rearranged clonal bands are indicated by arrows. DNA was digested with the restriction enzymes BamHI (lanes A-D) or EcoRI (lanes E,F). (Reprinted with permission of the American Society of Clinical Pathologists from the *American Journal of Clinical Pathology*).

exam revealed diminished bowel sounds, a liver span of twenty-three centimeters, a palpable spleen tip, and diffuse, mild tenderness. Extremity and neurologic examinations were unremarkable.

Pertinent laboratory data included WBC 220,000/mm^3 (25% segmented neutrophils, 7% monocytes, 1% lymphocytes, and 67% large mononuclear cells with multilobulated nuclei), hematocrit 39%, platelets 109,000/mm^3, calcium 12.0 mg/dl, albumin 3.2 gm/dl, alkaline phosphatase 525 U/I, SGOT 171 U/I, SGPT 35 U/I, LDH 3939 U/I. An arterial blood gas on 2 liters of nasal oxygen revealed pH 7.44, pCO2 25mm Hg and pO2 54mm Hg. Chest X-ray was notable for bilateral pleural effusions and diffuse interstitial markings. Head CT scan was normal. Cerebrospinal fluid cytology was negative.

Immediate review of all previous pathologic specimens confirmed that the atypical infiltrates seen in the biopsies of the bone marrow, colon, salivary gland, lip, liver, periaortic node, as well as the atypical cells seen in the pleural fluid and peripheral blood were similar (Figure 1). Lymphocyte marker studies of peripheral blood revealed monoexpression of T helper cells (CD4 93%, CD3 93%, CD5 94%, CD2 96%, CD8 1%, CD7 1%, CD19 0% HLA-DR 50%, and Leu8 48%; the HLA-DR and Leu 8 positive cells indicate activation antigens on some of the tumor cells; the lack of CD 7 marker demonstrates aberrant expression of T cell monoclonal antigens which is typical for T cell neoplasms). This clinical presentation was consistent with adult T-cell leukemia/lymphoma. This was supported by a positive EIA for HTLV-I antibody (performed by Specialty Laboratories, Inc., Los Angeles CA). HIV antibody titers were negative. Southern blot analysis revealed clonal rearrangement of the T cell receptor gamma and beta genes consistent with a monoclonal T cell neoplasm. Hybridization with the HTLV-I polymerase gene probe confirmed proviral integration (Figure 2).

Additionally, stool samples revealed the presence of *Isospora belli* oocysts (Figure 3). There were no *Strongyloides* larvae found and thiabendazole was discontinued as she had received a dosing schedule of 25 mg/kg for five days. The isosporiasis was treated with trimethoprim (160 mg) and sulfamethoxazole (800 mg) four times a day for ten days and then twice a day for a total of three weeks. Stool specimens were remarkable for heavy shedding of oocysts two days into therapy with none present after four days.

The patient's leukemia/lymphoma was treated with cyclophosphamide, doxorubicin, vincristine, prednisone, and prophylactic intrathecal methotrexate. She had an initial dramatic response with disappearance of the pleural effusions, peripheral lymphadenopathy, and hepatosplenomegaly. In mid-November, her WBC was 9,700/mm^3 without evidence of leukemic cells on peripheral blood smear.

In December 1987, however, her WBC increased to

30,000/mm^3 with relapse of her ATLL. Recurrent infection with both *Isospora* and *Strongyloides* was treated with thiabendazole 750 mg bid for 3 weeks and trimethoprim-sulfamethoxazole (320/1600) twice daily for ten days, then decreased to half this dose. Her clinical condition deteriorated over the next month with development of increasing tumor burden, respiratory failure, and eventual sepsis. The patient expired January 1988. Permission for postmortem examination was not obtained.

Discussion

This case is a classic presentation for adult T-cell leukemia/lymphoma, first described in Japan in 1977 as an aggressive proliferation of abnormal lymphocytes characterized by hypercalcemia, widespread lymphadenopathy, skin lesions, hepatomegaly, splenomegaly, and variable respiratory, gastrointestinal and central nervous system involvement.[1-6] Although the patient had been in the United States for 15 years, she was originally from southern Japan, an endemic region where antibodies to HTLV-I are found in up to one-third of the population age 30 or older. Patients often experience an asymptomatic latent period of years before the abrupt and aggressive proliferation of malignant lymphocytes occurs.[2-5] The high mortality rate in these patients results from the rapid, extensive dissemination of leukemic cells or from overwhelming opportunistic infections.

Both HTLV-I and HIV infections have been associated with malignancy, and both predispose to opportunistic infections. HIV has been shown to have a cytopathic effect on T4 helper cells. Alternatively, HTLV-I causes proliferation of the same population of lymphocytes. Exogenous infection of OKT4+ T cells with HTLV-I occurs and most of the lymphocytes do not undergo malignant transformation, although their immunologic function is impaired. In vitro studies show suppressive effects of HTLV-I infection on T helper, direct cytotoxic and natural killer cell function, although the mechanism of this suppression has yet to be elucidated.[7-9] Thus, as seen in our patient, opportunistic infection may precede the development of malignancy.[2-4,10,11] The HTLV-I provirus integrates randomly into the cellular genome and malignant transformation may occur in one of these cells with subsequent clonal proliferation, but this may take years, or may in fact never occur.[2-4] The presence of a single band on this patient's Southern blot analysis indicates a single integration site in this monoclonal tumor population (Figure 2).[12,13]

Opportunistic infections previously described in association with ATLL include *Pneumocystis carinii*, *Cryptococcus*, *Candida*, Cytomegalovirus, *Herpes simplex* virus, histoplasmosis, and as seen in this patient, *Strongyloides stercoralis*.[14] *Strongyloides stercoralis* is an intestinal nematode which can pose a major threat to the immunocompromised host due to

Fig. 3A (above), Phase contrast and Fig. 3B (below), modified Kinyoun stain of *Isospora belli* containing two sporoblasts isolated from patient's stool. Organism averages 15 × 25 uM in size.

its propensity for hyperinfection and dissemination in this setting, its frequent association with gram negative bacterial sepsis, and because it is often not considered initially in the differential diagnosis of such patients.[15-18] The association of HTLV-I and HIV with strongyloidiasis has been described, and with early recognition the initial infection and recurrences can be treated effectively.[9,10,13] In the normal host, treatment with thiabendazole (25mg/kg) for two days is recommended. Immunocompromised patients are usually treated for 5-7 days, and recurrent infections may necessitate chronic suppressive therapy. Patients should also be retreated prior to receiving steroids or chemotherapeutic agents.[15,16,18]

During the acute phase of this patient's malignancy, *Isospora belli* oocysts were found in her stool. Coccidial infections, which include *Isospora* spp. and *Cryptosporidium*, have been important clinically in association with AIDS and can be the presenting opportunistic infection of this syndrome, especially among Haitians.[19-23] There have been only two reported cases of *Isospora belli* infection in patients with ATLL.[24] Diagnosis is made by identifying immature and sporulated oocysts in stool by wet mount or modified acid-fast stain (Figure 3). Duodenal aspirates and small bowel biopsy may also be used for diagnosis.[19-21] Eosinophilia may be present, but as with *Strongyloides*, its absence does not exclude the diagnosis. Fecal leukocytes are usually not present. Also of note, one patient with AIDS at autopsy was found to have *Isospora belli* in mesenteric and tracheobronchial lymph nodes as evidence for dissemination.[22]

Our patient was treated with trimethoprim-sulfamethoxazole (160/800 mg) four times daily for ten days then twice a day for three weeks as previously recommended.[19] There is some thought that this may be excessive in that symptoms resolve in 2-3 days.[19] This patient was found to have a massive shedding of oocysts in her stool within 48 hours of therapy with subsequent negative stool examinations. Metronidazole and pyrimethamine plus sulfadiazine have also been successful in treating isosporiasis in small numbers of patients.[19] However, at least 50% of AIDS patients have recurrent *Isospora* infection within a short time. Therefore, prophylaxis with sulfadoxine (25 mg) and pyrimethamine (500 mg) weekly, or trimethoprim-sulfamethoxazole (160/800 mg) three times a week has recently been shown to be effective.[23]

Concurrent infections with other enteric pathogens can occur with *Isospora* infection. Approximately 5% of Haitian patients with AIDS and *Isospora* have been infected with either *Strongyloides*, *Giardia*, *Ascaris* or *Cryptosporidium*.[19] Multiple enteric pathogens have also been reported in a patient with HTLV-I infection.[14]

Summary

In summary, we present this as the first reported case of both isosporiasis and strongyloidiasis complicating HTLV-I-associated ATLL. Prompt diagnosis and treatment of these parasites in the immunocompromised host are necessary to prevent severe wasting and dehydration. This should also prevent the significant morbidity and mortality associated with dissemination well-described for *Strongyloides*, and recently seen at autopsy in a patient with isosporiasis. Recurrent infections are common with both organisms, therefore chronic suppressive therapy and prophylactic treatment prior to chemotherapy or steroid administration is warranted.

Dr. M. Yoshida, Cancer Institute, Tokyo, kindly provided the HTLV-I hybridization probe, and Dr. Donald J. Innes, Department of Pathology, University of Virginia Hospital, kindly provided the photograph of peripheral blood smear.

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ABSTRACTS

These abstracts derive from the annual meeting of the Virginia Society of Otolaryngology/Head and Neck Surgery in Alexandria April 19-21. Dr. Steven A. Davie and Dr. R. Jack Eastham presided.

Acoustic Neuroma: Diagnostic Techniques. Fred T. Shaia, MD, and Nancy L. Schay, CCC/A, Richmond.

In the past, the diagnosis of acoustic neuromas required a battery of audiological tests and invasive radiology techniques. It is now possible to limit the testing to two studies, an auditory brainstem evoked potential, the second a magnetic scan with enhancement. A patient with any one of the following should have an auditory brainstem evoked potential: 1) unilateral sensorineural hearing loss; 2) asymmetrical sensorineural hearing loss; 3) unilateral tinnitus; 4) dizziness. When the auditory evoked potential is abnormal in any of these situations, the physician is advised to proceed with a magnetic scan with enhancement. The auditory evoked potential is 98% reliable in detecting acoustic neuromas and should be the first and only test after an audiogram that is necessary for the diagnosis. If for some reason, such as a total sensorineural hearing loss, the brainstem study cannot be performed, then the magnetic scan with enhancement should be the required testing. With this format, the diagnosis of small acoustic neuromas and surgery with preservation of hearing is a genuine and reasonable goal.

Adenotonsillectomy in Children with Sickle Cell Disease. Craig S. Derkay, MD, James R. Thomsen, MD, Gregory J. Milmoe, MD, Gordon Bray, MD, and Kenneth M. Grundfast, MD, Norfolk.

The pediatric patient with sickle cell disease is at increased risk during adenotonsillectomy under general anesthesia because of the possible development of a vaso-occlusive episode. Although the indications for adenotonsillectomy may be similar to those in patients without hemoglobinopathies, careful pre-operative planning in collaboration with the hematologist is mandatory. This report reviews management for 10 children, ranging in age 4–14, with sickle hemoglobinopathies who had adenotonsillectomy. Indications for surgery were recurrent streptococcal infections in 4 and obstructive sleep apnea in 6 of these children. There were no complications resulting from any of these procedures and the mean duration of hospitalization post-operatively was 2.0 days. The principal feature of pre-operative management was the administration of red blood cell transfusions designed to suppress the patient's endogenous erythropoiesis and

reduce the concentration of sickle hemoglobin to less than 30%. During surgery, patients were kept hydrated with intravenous lactated ringers at 1.5-2.0 maintenance while oxygen saturation was continuously monitored with a trans-cutaneous oxygen monitor.

Our experience indicates that adenotonsillectomy can be performed safely in children with sickle hemoglobinopathies.

Oncocytic Malignancy of the Parotid Gland. Richard L. Scher, MD, Philip S. Feldman, MD, and Paul R. Lambert, MD, Charlottesville.

Oncocytic malignancy of parotid gland origin is a very rare neoplasm. A combination of cytologic, histologic, histochemical and ultrastructural evaluation is necessary to differentiate this salivary gland malignancy from other parotid neoplasms with cells exhibiting oncocytic features. Since 1984 we have diagnosed and treated 4 patients with oncocytic carcinoma originating in the parotid gland. Two of these patients presented with facial paralysis as their initial symptom, with all cases demonstrating extensive perineural invasion in the pathologic specimen. An initial diagnosis of oncocytic malignancy was correctly made preoperatively in each case with cytologic analysis obtained by fine-needle aspiration. These patients have been treated with aggressive surgical resection followed with external beam radiotherapy, with all patients presently alive 3-56 months after diagnosis. This report will discuss the clinical and pathologic features of this rare malignancy, and by reviewing these and previously reported cases, suggest rational treatment options based on the biologic behavior of these tumors.

Angioedema of the Head and Neck Associated with Angiotensin Converting Enzyme Inhibitors. John F. Huhn, MD, Timothy R. Jones, MD, Marc A. Seftel, MD, W. Copley McLean, MD, and Carlos R. Ayers, MD, Charlottesville.

Angioedema of the head and neck is a potentially life-threatening condition of uncertain etiology. Recent experience of 11 patients with angioedema associated with angiotensin converting enzyme (ACE) inhibitors was reviewed to provide guidelines for appropriate diagnosis and management of this condition. Analysis of patient data revealed a median onset of symptoms 30 days after initiation of ACE inhibitor therapy with a range of 2 days to 10 months. Hospitalization was required in 6 patients with a mean stay of 2 days. Four cases are discussed to illustrate the broad range of clinical presentation, including severe respiratory distress. Treatment recommendations include discontinuation of any ACE inhibitor, airway maintenance measures, steroid administration, and control of hypertension with an alternative medication.

Definitive Emergency Laryngectomy. Michael A. Seicshnaydre, MD, Anthony W. Jackson, MD, and Mary Ann Smith Frable, MD, Richmond.

Three tumor patients presented at the Medical College of Virginia Hospitals, Virginia Commonwealth University, with life threatening complications. Two patients had airway obstruction from large laryngeal neoplasms and one had hemorrhage from a tumor arising at the base of the tongue. The hemorrhage could not be controlled by medical means. All patients underwent emergency laryngectomy. The authors review all three cases and discuss the pros and cons of their surgical approach.

Audiologic and Electrophysiologic Findings in Patients with Benign Intracranial Hypertension. Richard Callari, MD, Tucker Cook, CCC/A, Susan Fowler, CCC/A, and Aristides Sismanis, MD, Richmond.

We have previously reported that pulsatile tinnitus and hearing loss can be the major or only manifestations of benign intracranial hypertension (BIH) syndrome. Between 1981-89 31 patients with BIH syndrome associated with otologic symptoms have been diagnosed at the Medical College of Virginia. A prospective evaluation with audiometric testing consisting of puretone (air and bone conduction), speech discrimination, tympanometry and auditory evoked responses was carried out. The results of this prospective study are to be reported in this communication. We have strong evidence that intracranial hypertension can have a direct or indirect effect on the auditory system resulting in hearing loss. The pathophysiology of these processes are to be presented in detail.

Office Computerization: Benefits and Pitfalls. Charles M. Johnson III, MD, Charlottesville, and Steven A. Davie, MD, Blacksburg.

This discussion will consider the use of both the micro- and mini-computer in the organization of the medical office, particularly for otolaryngologists. It will include what these computers can do, what they can not do, and what one can reasonably expect an adequate software program to accomplish. It will also discuss what the practicing otolaryngologists should be looking for in any company selling medical software systems. This report is a direct outgrowth of the Computer Committee of the Virginia Society of Otolaryngology.

Surgical Management of Massive Parapharyngeal Space Neurofibroma. Michael Stamm, MD, and Anthony W. Jackson, MD, Richmond.

Neurogenic tumors are the second most common primary tumors of the parapharyngeal space. These tumors are usually benign and slow growing. Symptoms are produced by pressure on neighboring structures. These neoplasms expand in the directions of least resistance. Eventual mandibular displacement

and deformity can occur secondary to parapharyngeal space neurofibroma that is allowed to progress. The authors will discuss the anatomy of the parapharyngeal space along with the most common neoplasms found in this area. We will then review the genetics and pathology of neurofibromatosis and report about a case of massive plexiform neurofibroma of the parapharyngeal space treated at our institution. We recommend surgical removal of these neoplasms prior to massive growth that causes bony deformities and airway compromise.

Lymphoma of the Temporal Bone. Debara L. Tucci, MD, John F. Huhn, MD, and Paul R. Lambert, MD, Charlottesville.

Primary temporal bone lymphoma is a rare clinical entity. The single previously reported case describes a patient who presented with progressive facial weakness 2 years following surgical resection and radiotherapy for a lymphoma of the parotid gland. We report on two patients with primary temporal bone lymphoma, both of whom presented with facial paralysis. One patient, an elderly man, demonstrated complete recovery of paralysis after the first course of chemotherapy. One year after initial presentation this patient has extensive metastatic disease without current evidence of persistent disease in the temporal bone. The other patient, a 5-year-old boy, has shown no improvement in facial function 3 months after initiation of treatment.

Pediatric Otolaryngology Procedures in the United States 1977-1987. M. J. Kelleher, MD, and C. S. Derkay, MD, Norfolk.

Utilizing data provided in the National Health Survey, common pediatric otolaryngology procedures for the year 1977 through 1987 were analyzed. Uniform data was available for adenotonsillar surgery and myringotomy with insertion of ventilation tubes. Parameters examined included: total procedures, rates of procedure per 100,000 population, differences in sex, age and race of patients, changes in length of hospital stay, variations in surgical rates based on size of the hospitals, and regional variations in surgical rates and length of stay. Although adenotonsillar surgery remained the most frequent surgical procedure performed on children under 15 years of age, the total number of procedures and the rate per 100,000 population declined by over 50%. In the 10 years studied, tonsillectomies decreased from 414,000 to 197,000 total procedures in the age group less than 15 years and from 291 per 100,000 to 134 per 100,000 children. A similar decline was noted in the rate and numbers of myringotomy and tube insertions. A review of the available literature on past and present numbers of otolaryngic procedures is presented. Potential explanations for and implications of these declining figures are discussed including the effects of institutionalized guidelines, reimbursement pressures, increasing manpower and changing venues in which these procedures are performed.

The Medical College of Virginia Smell and Taste Clinic: A Preliminary Report. M. G. Mellis, MD, A. Sismanis, MD, R. J. Delorenzo, MD, W. W. Campbell, MD, P. G. Heywood, MS, and R. M. Costanzo, PhD, Richmond.

Recent advances in the pathophysiology of chemosensory function have led to renewed interest in the treatment of patients with smell and taste disorders. We report the preliminary findings of such patients seen during the first year of the newly established MCV Smell and Taste Clinic. Patients underwent a complete otolaryngologic examination including nasal endoscopy and special olfactory function testing. In approximately one-third of the patients, we were able to establish a rhinologic cause responsible for their olfactory dysfunction. Topical intranasal steroids provided symptomatic benefit in many of these patients. Patients treated surgically had excellent results verified by improved scores on the MCV olfactory function test. We recommend that patients with smell and taste disorders undergo thorough evaluation including nasal endoscopy and formal chemosensory (smell and taste) function testing. Greater physician awareness of recent advances and the availability of specialized diagnostic tests will lead to improved diagnosis and treatment of patients with smell and taste disorders.

Head and Neck Reconstruction Using Surgical Flaps: Classification, Clinical Considerations, and Pertinent Physiology. Michael F. Pratt, MD, and Sherard Tatum, MD, Norfolk.

Over the years the use of flap reconstruction in head and neck surgery has become commonplace. There have been many recent advances in the understanding and classification of these flaps. They have enhanced the rehabilitation of cancer and trauma patients by permitting immediate resurfacing of large skin and mucosal wounds, carotid artery protection, immediate restoration of near-normal physiology, and complicated multi-staged reconstructive techniques. This presentation will include a classification of flaps commonly used in head and neck reconstruction based upon a scientific understanding of vascular anatomy and a discussion of basic clinical considerations in flap design and flap physiology. Many forms of therapy have been used in recent years to improve tissue survival in skin flaps. Most are focused on improving tissue oxygenation or decreasing metabolic needs. An outline of new work in our laboratories designed to investigate the pharmacologic enhancement of random skin flaps will be presented.

VIRGINIA MEDICAL

EDITORIAL

No Smoking

An earlier article in Virginia Medical (November, 1988) queried hospitals in Virginia in regard to smoking on hospital premises. A questionnaire was mailed to 115 hospitals and of the 97 responding only one banned smoking entirely. Four allowed complete freedom to smoke and the remaining 92 restricted smoking in various ways. An editorial in the same issue suggested a gradual approach to the elimination of smoking, with the first step being restriction of smoking everywhere except for a single designated area.

It appears that a modification of this approach has been adopted. Last fall the Virginia Hospital Association's Board of Directors called for member hospitals to adopt smoke-free policies by January 1, 1990, and to implement a full-scale smoking policy by January 1, 1991. The VHA defines a smoke-free facility as one which "bans smoking everywhere, except in substance-abuse or psychiatric wards. Patients are allowed to smoke only in private rooms. A smoke-free facility also phases out designated smoking areas for staff and visitors."

A recent issue of *Airways*, a publication of the American Lung Association of Virginia, lists 16 Virginia hospitals as smoke-free under the definition for 1990. Nineteen more plan to become smoke-free by January 1, 1991. As this was being written a communication arrived from the Medical College of Virginia, announcing inception of a smoke-free policy as of the first of May 1990. E.L.K., Jr.

Lies and Cynicism

The long ride to Richmond is only partially alleviated by listening to public radio stations, but this program was much more interesting than usual. The interviewee was the author of a recent book on the current level of public cynicism. The question under discussion was, of course, how much more cynical had the public become about politicians, government, big business and life in general.

Both interviewer and interviewee agreed that recent events had definitely had a negative effect upon the public: negative political campaigning, congressional ethics or the apparent lack thereof, executive branch sleaziness in pursuit of personal gain, big oil's lack of preparation for big oil spills in spite of multiple assurances before the fact, insider trading on the stock market, bending the rules to make $500 million dollars a year, etc.

Yes, the average American's trust in government, business and his fellow man had fallen dramatically. Cheating and lying were expected, anything to get ahead was the norm, manual labor was in disrepute, and cynicism was rife in the land.

Listening to this negative vein of thought, I considered that things were better in our rural area. In the mountains of Patrick County around my farm the people still value honesty, integrity, hard work, honor, duty, country.

My good friend, Wallace, is one of those traditional people. He voluntarily served two terms in the military forces. He personally built his modest home with help

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only from his wife and two small boys. In his many past vocations he had served as an officer of the law, had farmed, and had retired only when totally disabled.

Many times Wallace has told me, "Doc, I always tell the truth. You can't catch a man in a lie if he is telling the truth."

But then he pauses and adds, "Of course, if I'm losing the argument, I might have to lie just a little."

H. S. Campell, MD

Medical Research Funding

Grant funding for medical research is lagging. The administration's request of $7.930 billion for the Naitonal Institutes of Health for FY 1991 does not provide sufficient funds to fully support the current level of effort. Funding for research grants in 1989 provided sufficient monies for only 29 percent of those applications recommended for funding. The FY 1991 funding rate for new and renewal research grants will result in an all-time low.

The Ad Hoc Group for Medical Research Funding, composed of approximately 140 American research organizations and including the Association of American Medical Colleges, recommends an increase to $9.237 billion. Such an increase has the potential of adding millions of dollars for biomedical research and training to all three Virginia medical schools, as well as other graduate and research programs in the state. This added funding is badly needed. Write to your congressman.

E.L.K., Jr.

Guest Speaker: The Physician as Manager, an Exhortation

We live in a period in which the demands on physicians continue to grow. These pressures include demands for more of our time, for more teaching, and for more perfection in practice. At the same time there are increasing problems with substance abuse, family discord, suicide, depression, and physician "burnout." While there may be a number of reasonable strategies for dealing with these demands, the principles of good management must have a prominent place in our approach to these challenges.

First of all, doctors need to know how to manage people. They should be managers, leaders, and teachers of residents, students, patients, families, nurses, and other health care workers. How can we successfully fill these roles? There is no substitute for personal interest. We must understand all kinds of people and their priorities. Optimal communication is important and is enhanced by explaining, when feasible, what your requests entail. Such explanations decrease the chance for error, increase the chance for adaptation when necessary, and are compliments to your coworkers. Remember that there are differences between effectiveness and popularity. We must also understand the differences between motivation and manipulation. We must avoid being domineering, intimidating, and arrogant. The best leaders, teachers, and managers are approachable, communicative, and enthusiastic. They praise good performances and build self-esteem. High self-esteem leads to high performance. Constructive feedback, adding positive comments when criticism is necessary, is another principle of good management.

Second, physicians should be experts in time management. We all complain that there is not enough time. However, the central issue is not how much time there is; the crucial aspect of time is how we manage it. After all, everyone has the same 24 hours in each day. Unfortunately, most of us manage time poorly. We all know the world is full of competent people with good intentions who don't accomplish as much as they should. The most common cause of this shortcoming is poor time management. Time is managed best by making lists, breaking down problems to achievable tasks, and assigning priorities. Most of us are very good at making lists but are inept at assigning priorities. In order to assign priorities properly, one must understand the difference between urgency and importance. Things that are urgent are pressing, demanding and seemingly relentless. They seem to call for immediate action, usually to the exclusion of all else. Examples of urgency in the personal realm include hunger, sleep, and protection of our egos. Examples in the educational realm include artificial deadlines, assignments, reports, and tests. Examples of urgency in the patient care arena include focusing on minor details such as isolated lab values or getting caught up in performing a specific procedure like an intravenous line during a resuscitation while ignoring the patient's overall condition or needs such as a cervical spine injury. However, many things that are urgent are not all that important and many things that are important are not all that urgent. Things that are important are things that are significant, meaningful, substantial, and of long-term consequence. Examples in the personal realm include exercise, recreation, health, personal values, religion, and family. Examples of things that are important in education include learning general principles rather than isolated facts. Also important but often of little urgency is the need for good teaching. Examples of things that are very important in the medical realm, but often are not very urgent, are the feelings and dignity of patients and their families or consideration of their quality of life. There is an old adage that reminds us that trivial matters are handled promptly while important ones are often never handled at all.

To acquire the necessary management skills, which include negotiating techniques, public speaking, teaching techniques, delegating, and leadership skills, we must continuously educate ourselves. We must be observers and connoisseurs of good management practices, looking for examples and role models inside and outside of medicine. There are many educational opportunities in this area, such as books, tapes, seminars, and courses.

In conclusion, the principles of management will be valuable to us as we face the many demands on the physicians of the future. Utilizing these principles will help our profession to grow stronger, more vital and more effective instead of succumbing to the pressures and challenges we face.

Curtis G. Tribble, MD

Excerpted from Dr. Tribble's baccalaureate address to the University of Virginia School of Medicine delivered on 24 May 1989. Address correspondence to him at the Department of Surgery, Box 181, University of Virginia Health Sciences Center, Charlottesville VA 22908.

VIRGINIA MEDICAL OBITUARY

• **William M. Bickers, MD,** longtime obstetrician/gynecologist in both Richmond and the Far East; Medical College of Virginia, 1904; age 82; died May 5, 1990.

• **William Walker Butzner, Jr., MD,** retired Fredericksburg family practitioner; University of Virginia School of Medicine, 1935; age 78; died April 27, 1990, in Easton, Maryland. He had twice served as president of the Fredericksburg Area Medical Society.

• **David Samuel Garner, MD,** retired Roanoke family physician; Medical College of Virginia, 1933; age 91; died May 6, 1990. He had been president of the Roanoke Academy of Medicine and of Blue Shield of Southwest Virginia.

• **Kermit Jackson Moore, MD,** family physician in Petersburg for 45 years; Medical College of Virginia, 1934; age 79; died April 15, 1990.

• **Marion D. Richmond, MD,** Martinsville pediatrician; Medical College of Virginia, 1959; age 57; died May 19, 1990.

Memoir of Frank Strickler 1908-1989

By Julian B. Doss, MD

Frank A. Strickler, MD, of Roanoke was born on July 12, 1908, and died September 9, 1989, at age 81.

Dr. Strickler grew up in Bridgewater, Virginia, and attended school there. He graduated from Bridgewater College, where was valedictorian of his class of 1928 and he was active in athletics. He then attended the University of Virginia School of Medicine, earning his MD degree in 1932. He served his residency in neuropsychiatry at the University of Virginia Hospital and continued his training at Stuart Circle Hospital in Richmond. As a staff member at New York City Hospital, he developed an osteomyelitis of the right upper arm that crippled and tormented him lifelong.

In 1942 he was staff member at St. Albans Hospital in Radford and a consultant in psychiatry at the Veterans Administration Hospital in Salem, Virginia. In 1943, Dr. Strickler established his private practice of neurology and psychiatry at the Medical Arts Building in Roanoke, Virginia continuing as a consultant at the VA Hospital in Salem. He retired in 1982.

Dr. Strickler was among the pioneers in the field of neuropsychiatry as consultant and counselor. He was always friendly, kind and gentle. A real gentleman.

He was a member of the Church of the Bretheren, the Roanoke Valley Academy of Medicine, the American Psychiatric Association and The Medical Society of Virginia.

He is survived by his wife of 55 years, Mrs. Sylvia Shafer Strickler, and one brother, Stanley S. Strickler, both of Roanoke.

Memoir of Monford Custer 1914-1989

Dr. Monford D. Custer, Jr., died on November 23, 1989, after a distinguished medical career and long-term service to the Winchester community. Born in Coshocton, Ohio, on December 5, 1914, he was graduated from the Lawrenceville School in 1932, Princeton University in 1936, and Columbia University School of Physicians and Surgeons in 1940. After an internship at Robert Packer Hospital in Sayre, Pennsylvania, he began a fellowship in general surgery at the Mayo Clinic and Foundation in Rochester, Minnesota. His period of study was interrupted by World War II, at which time he served as a captain in the United States Army in Louisville, Kentucky, and chief of surgery at an army hospital in Puerto Rico. Following his service time, he returned to the Mayo Clinic to complete his fellowship and obtain a Master of Science in surgery from the University of Minnesota.

He and his wife, Lucy, came to Winchester in 1947, and Dr. Custer began an illustrious medical career which continued through his retirement in 1981. He started on the medical staff of the Winchester Memorial Hospital, served on many committees and was elected to the presidency of the staff in 1963. He was certified by the American Board of Surgery in 1948, and became a fellow in the American College of Surgeons in 1949. He published many scientific articles and editorials in national surgical journals.

In addition to membership in the AMA and The Medical Society of Virginia, he was a member of the Priestley Society of the Mayo Clinic and the Virginia Surgical Society, of which he was president in 1968. He was vice president in 1970 of the Southern Surgical Association and was the secretary for five years of the Southern Society of Clinical Surgeons and its presi-

dent in 1975.

One of his proudest accomplishments was the realization of establishing in Winchester in the 1950s the Winchester Surgical Clinic. Initially a general surgery group of Drs. Boyd, Horgan, Miller and Custer, it has ultimately grown to a multispecialty surgical group of 15 professionals practicing general, orthopedic, cardiovascular, thoracic and urologic surgery. In recognition of his worthy efforts and appreciation for the time and energy he extended in initiating the formation and ensuring the success of the Clinic, the building it presently occupies was dedicated to Dr. Custer prior to his retirement in 1981 and is known as the Monford D. Custer, Jr., Building.

His community interests were widespread and far-reaching. He was a long-time member of Christ Episcopal Church and served as vestryman and subsequently as warden. He was a member of the Handley Library Board, and served as chairman of the Development Committee when the new addition was realized. Dr. Custer was an active member of the Winchester Parking Authority, and subsequently served as chairman during the period when the first downtown parking garage was established. His life-long interest in golf enabled him to serve as president of the Winchester Country Club and subsequently become a founder and president of the Carper's Valley Golf Club. In 1968 he received the Citizen of the Year Award from the Winchester-Frederick County Chamber of Commerce.

During the 1970s Dr. Custer volunteered for service on the S.S. HOPE Hospital Ship, and subsequently became a strong supporter of Project HOPE and its headquarters relocation in Millwood, Virginia.

A very significant impact on the Winchester community has been made by the generosity of the Custer family, mainly in the areas of medicine, nursing, education and recreation. Dr. Custer, as a trustee of the Gallagher Foundation and through his own personal generosity, was instrumental in supporting many individual projects at Winchester Medical Center and assisted in establishing the Free Medical Clinic in its refurbished building. As a trustee of the Shenandoah College and Conservatory of Music and a recipient of its Distinguished Service Award, Dr. Custer, along with Mrs. Custer, was pivotally instrumental in ensuring the restoration of the Old John Kerr Building and its conversion to the Eleanor Wade Custer School of Nursing, Arts Center and Community Education Facility. This accomplishment will have a long-lasting influence on education, nursing and medicine in this community.

Dr. Custer married Lucy (Tide) Ellen Lamb of Mount Vernon, Ohio, in 1938. They had three daughters, Ellen C. Morgan of Los Angeles, California; Susan C. Sanders of Savannah, Georgia; and Linda C. Russell of White Post, Virginia; and one son, Dr. Monford D. Custer III of the Scott & White Clinic in Temple, Texas. He was an avid fisherman, testing the waters from Pakistan to Alaska with his son, as well as the local waters of the Shenandoah River with his grandsons. The community of Winchester and the medical profession have lost a truly generous man, a leader with vision and accomplishment, a caring physician, and a Christian family man who enjoyed every aspect of his life. May he rest in peace.

Submitted for publication by the physicians of the Winchester Surgical Clinic.

Memoir of Peter Pastore 1907-1989

By George H. Williams, MD, Kinloch Nelson, MD, and Elam Toone, Jr., MD

Dr. Peter N. Pastore was born in Bluefield, West Virginia, on November 8, 1907, and died in Richmond, Virginia, on September 16, 1989.

He was graduated from Bluefield's Beaver High School in 1926, continued his education for two years at Bluefield College, then received a BA degree from the University of Richmond in 1930, where he was a member of Phi Beta Kappa. His medical degree was earned at the Medical College of Virginia in 1934, where he became a member of Alpha Omega Alpha, and where he completed his internship and residency in 1936. He trained as a fellow at the Mayo Clinic and received an MS, Otolaryngology, from the University of Minnesota in 1939. In 1942 he became the first professor and chairman of the Department of Otology, Rhinology, Laryngology, Audiology and Speech Pathology at the Medical College of Virginia and so served until his retirement in 1976. As emeritus professor, he maintained an active role in student and resident education.

Dr. Pastore was always a dedicated academician with a precise mind, a gentle touch, and a sincere interest in students, patients, and colleagues. He was a tenacious researcher with a driving desire for documentation of all events, whether medical, historical, or simple relaxation with family or friends. His camera was always within reach and ready for action. He had an interest in the McGuire Veterans Administration Medical Center and was chief of otolaryngology there until 1976, after which he served as director of continuing medical education for otolaryngology until his death. He also served on the faculty of the American Academy of Ophthalmology and Otolaryngology from 1951 until 1975. Dr. Pastore had more than 45 scholarly articles covering all aspects of otolaryngology and medicine in general.

Dr. Pastore was president of the Richmond Eye, Ear, Nose and Throat Society, 1945-46; president of

the Virginia Society of Ophthalmology and Otolaryngology, 1952-53; president of the International Association to Secretaries of Ophthalmological and Otolaryngological Societies, 1959-62; president of the Medical College of Virginia Alumni Society, 1961-62; president of the American Cancer Society, Richmond Unit, 1960-61; and president of the International College of Surgeons, Virginia Division, 1962-64. He was on numerous boards and a member of most of the major medical, surgical and otolaryngological societies.

Dr. Pastore had a strong commitment to the community and religious organizations. He was president of the Catholic Physicians Guild, 1962-64 and of the board of Benedictine High School, 1964-66, and at his death was a member of the advisory boards of Benedictine and the National Council for Christians and Jews. He was president of the Easter Seal Society of Richmond, 1967-70, and served as treasurer of that organization, 1980-85. He was on the boards of The Richmond Children's Aid Society, 1944-47, and the Virginia Society for Crippled Children and Adults, 1954-74. He received numerous honors and awards, including: Medical-Scroll, Algernon Sydney Sullivan Award in Recognition of Spiritual and Humanitarian Service, 1982; Outstanding Contributions to the Communicatively Handicapped in Virginia, 1980; Virginia Cultural Laureate Society, Laureate of Virginia, 1986; Award for Long Years of Commitment and Service to the Lives of People with Disabilities, Easter Seal Society of Virginia, and the Presidential Medallion, Virginia Commonwealth University, 1987.

Dr. Pastore was founder of several funds and services. He was the first director and lecturer, Medicine and Medical Advances, 1983, Elderhostel. He established the Peter N. and Julia Pastore Professorship in Otolaryngology Fund through the Medical College of Virginia Foundation. In 1977 he founded the Pastore Otolaryngology and Medical Artifacts Historical Collection, Medical College of Virginia/Virginia Commonwealth University, Tompkins-McCaw Library Special Collections Archives and devoted much of his time and resources to the artifacts collection during his retirement years. It is a tribute to his desire to document and preserve history.

Dr. Pastore was a true Southern gentleman, a very kind and a very gracious person. He endeared the hearts of those who had the privilege to meet him, and it is unlikely he ever met a person he did not like. He was a devoted husband and father with strong religious convictions. He was a friend and a humanitarian par excellence.

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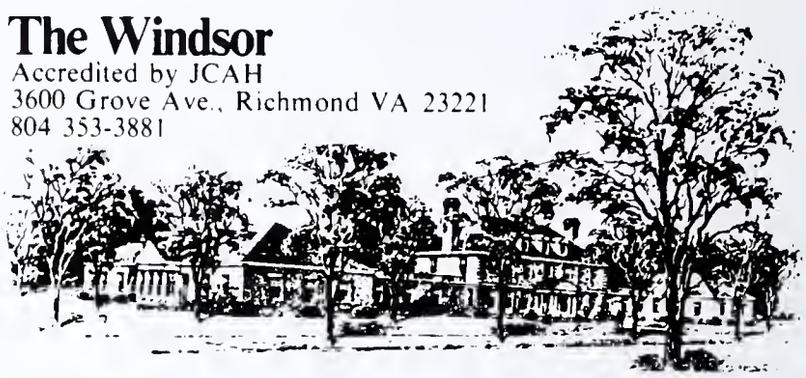

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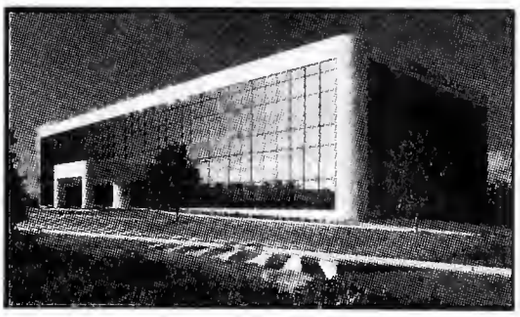

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continued on page 331

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–From Dosage and Administration section of complete prescribing information for Calan SR.*

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†For adult hypertensives only.

Please see references and a brief summary of prescribing information on adjoining page.

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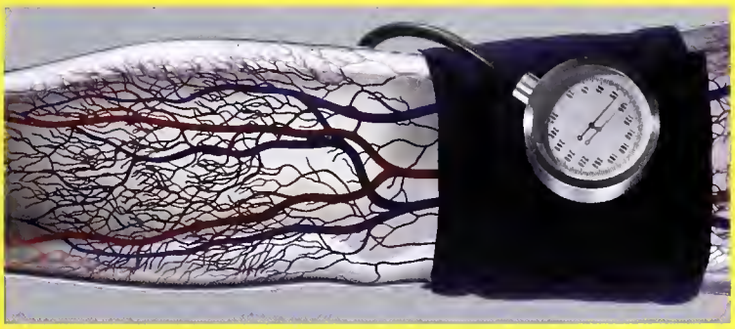

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In mild to moderate hypertension

*Lower initial doses of 120 mg a day may be warranted in patients who have an increased response to verapamil (eg, the elderly or those of small stature)

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence. 12/21/89 • P90-W198V

References:

1. Reinfronk J, Eckardt A, Schneider G, et al: Long-term efficacy and safety of verapamil SR 240 mg in hypertension. *Acta Therapeutica* 1989;15:221-235. **2.** Saunders E, Weir MR, Kang BW, et al: A comparison of the efficacy and safety of a beta blocker, calcium channel blocker, and converting enzyme inhibitor in hypertensive blacks. *Arch Intern Med* (accepted for publication). **3.** Speders S, Sosna J, Schumacher A, et al. Efficacy and safety of verapamil SR 240 mg in essential hypertension: Results of a multicentric phase IV study. *J Cardiovasc Pharmacol* 1989;13(suppl 4):S47-S49. **4.** Henry JA, Chester PC, Latham AN. Sustained-release verapamil or atenalol in essential hypertension. *J Drug Dev* 1988;1:69-75. **5.** Midtba KA, Hals O, Louve O: A new sustained-release formulation of verapamil in the treatment of hypertension. *J Clin Hypertens* 1986;3:125S-132S. **6.** Bachsler JA, Simmons RL, Ward PJ, et al. Verapamil SR and propranolol LA. A comparison of efficacy and side effects in the treatment of mild to moderate hypertension. *J Hum Hypertens* 1988;1:305-310. **7.** Data on file, G.D. Searle & Co.

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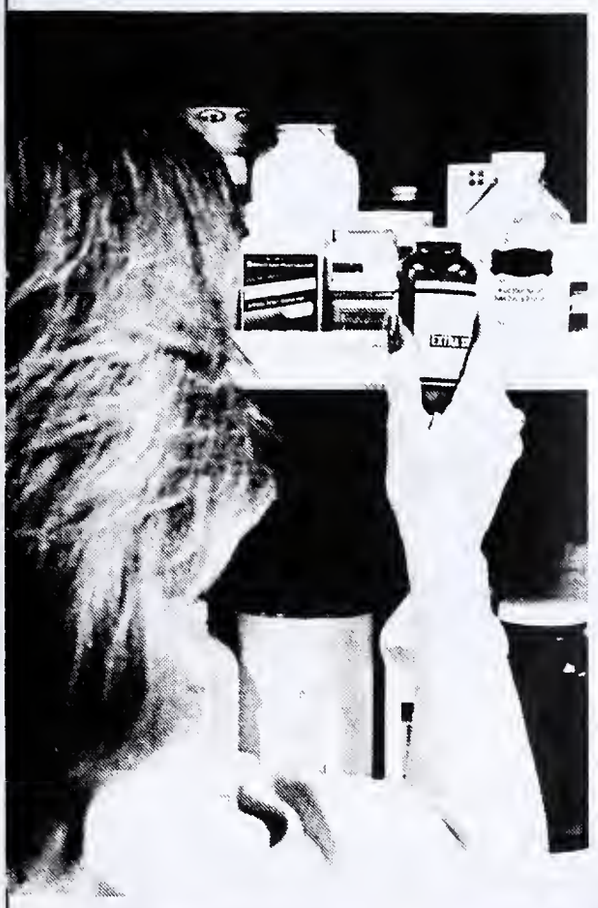

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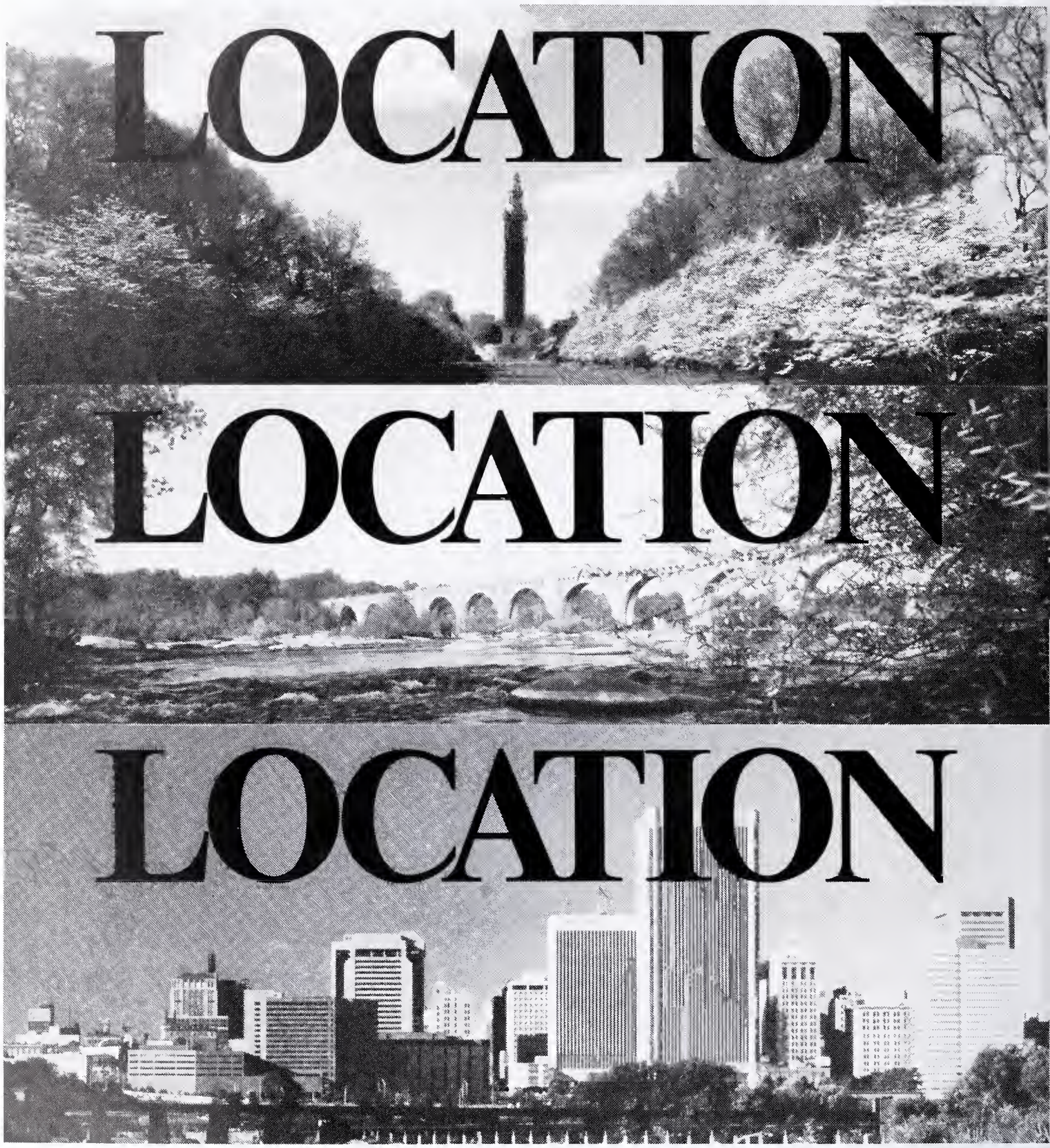

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1990 Annual Meeting
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August 10-12
Diabetes and Vascular Disease (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

August 24-27
12th Edition, Practical Dermatology for the Primary Care Physician (Eastern Virginia Medical School), *Orlando, Florida*. CME Office, 804-446-6140.

September 7-9
Annual Meeting/Scientific Session of the Virginia Vascular Society, The Homestead, *Hot Springs*. Dr. Jesse Davidson, program chairman, 703-345-1561.

September 8
Regular meeting of the Medical Society of Virginia's Council, *Richmond*. James L. Moore, Jr., 804-353-2721.

September 8-11
Addictions Conference (Oxford Institute Network of Care), *Hilton Head Island, South Carolina*. Mary Johnson, 1-800-726-4044.

September 10-14
Basic Course in Nosocomial Infection Control (University of Virginia). *Charlottesville*. Debbie Crickenberger, 804-924-2777.

September 13-14
Pediatrics for the Practitioner: Update 1990 (Johns Hopkins), *Baltimore*. 14.5 credit hrs. Physician fee: $235. CME Office, 301-955-2959.

September 14-16
Plastic Surgery of the Eyelids and Orbit/Oculoplastic Surgery, a Multidisciplinary Symposium (Eastern Virginia Medical School), *Norfolk*. CME Office, 804-446-6140.

September 27-28
5th Annual Postgraduate Radiology Course: Update in Film Screen Mammography (University of Virginia), Jefferson Sheraton Hotel, *Richmond*. 15 credit hrs. Physician fee: $300. R.L. Boswell, 804-924-9387.

September 28
13th Annual Perinatal Conference (Medical College of Virginia/VCU). *Richmond*. CME Office, 804-786-0494.

October 3-5
Recent Advances in Clinical Medicine (University of Virginia), Omni Hotel, *Charlottesville*. Lauvonda Young, 804-924-2090.

October 3-6
16th Annual Topics in Gastroenterology and Liver Disease (Johns Hopkins), *Baltimore*. 23.5 credit hrs. Physician fee: $425. CME Office, 301-955-2959.

October 4-6
Virginia Occupational Health Conference (Medical College of Virginia/VCU, *Richmond*. CME Office, 804-786-0494.

October 8-11
13th Annual Postgraduate Course in Radiology (University of Virginia), Boar's Head Inn. *Charlottesville*. 20 credit hrs. Fee: $400. Dr. Theodore E. Keats, 804-924-2781.

October 8-12
Basic Course in Nosocomial Infection Control (University of Virginia), *Charlottesville*. Debbie Crickenberger, 804-924-2777.

October 11-13
Management of the Spinal Cord Injured Patient: Pediatric, Aging, and Elderly (Eastern Virginia Medical School), *Virginia Beach*. CME Office, 804-446-6140.

October 22-27
32nd Annual Emil Novak Memorial Course: Gynecology, Gynecological Pathology, Endocrinology, and High-Risk Obstetrics (Johns Hopkins), *Baltimore*. 44.5 credit hrs. Physician fee: $650. CME Office, 301-955-2959.

November 1-4
Advances and Controversies in Internal Medicine Seminar (Lloyd Noland Hospital), the Greenbrier, *White Sulphur Springs, West Virginia*. CME Office, 205-783-5276.

November 3
Symposium on Current Controversies in Colon and Rectal Cancer (University of North Carolina at Chapel Hill), *Research Triangle Park, North Carolina*. CME Office, 919-962-2118.

November 8-9
15th Annual Symposium for Clinicians on Hospital Infection Control (University of Virginia), Boar's Head Inn, *Charlottesville*. Debbie Crickenberger, 804-924-2777.

November 29-December 1
Advances in Obstetrics and Gynecology (Medical College of Virginia), *Richmond*. CME Office, 804-786-0494.

December 7-9
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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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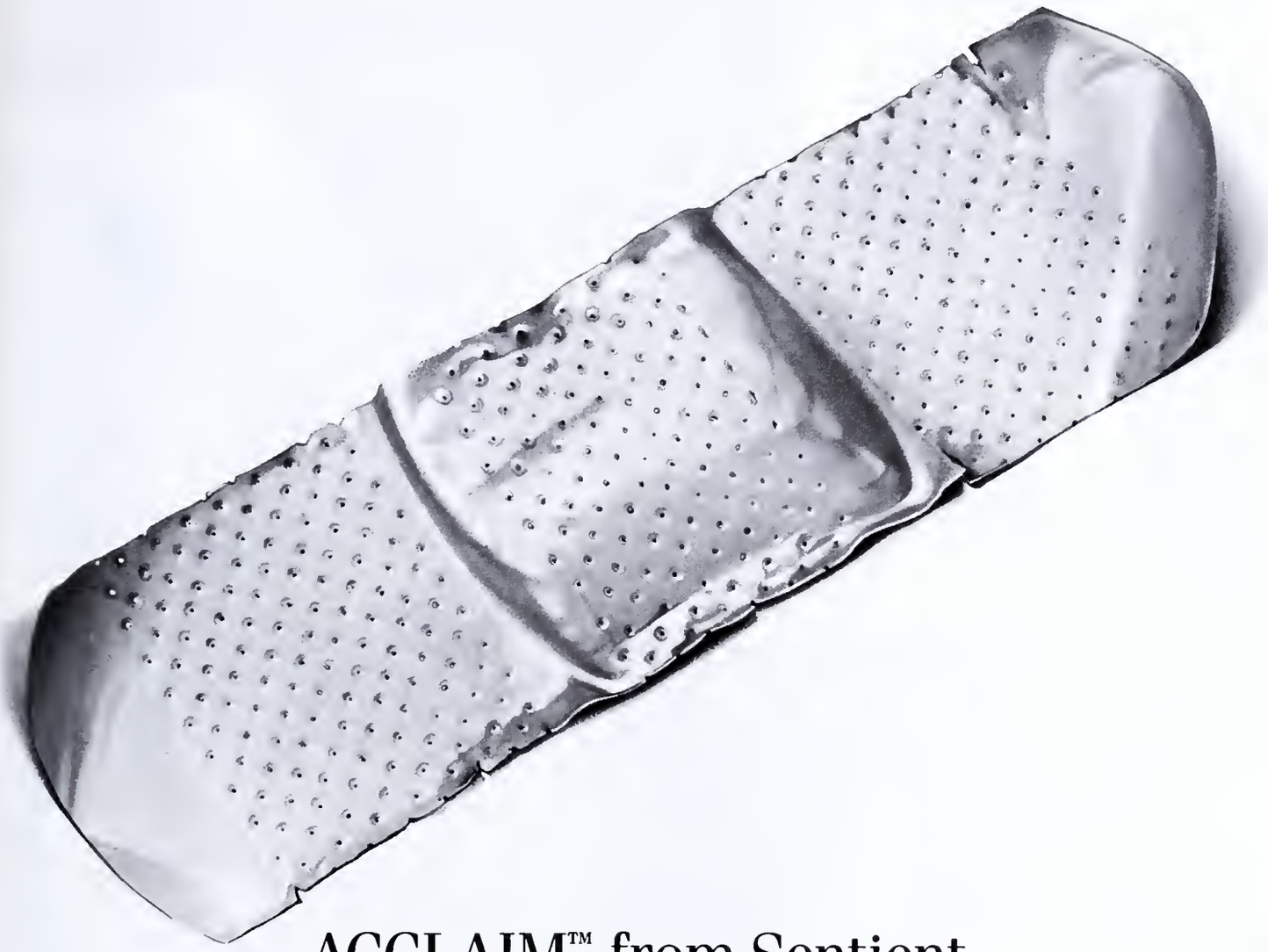

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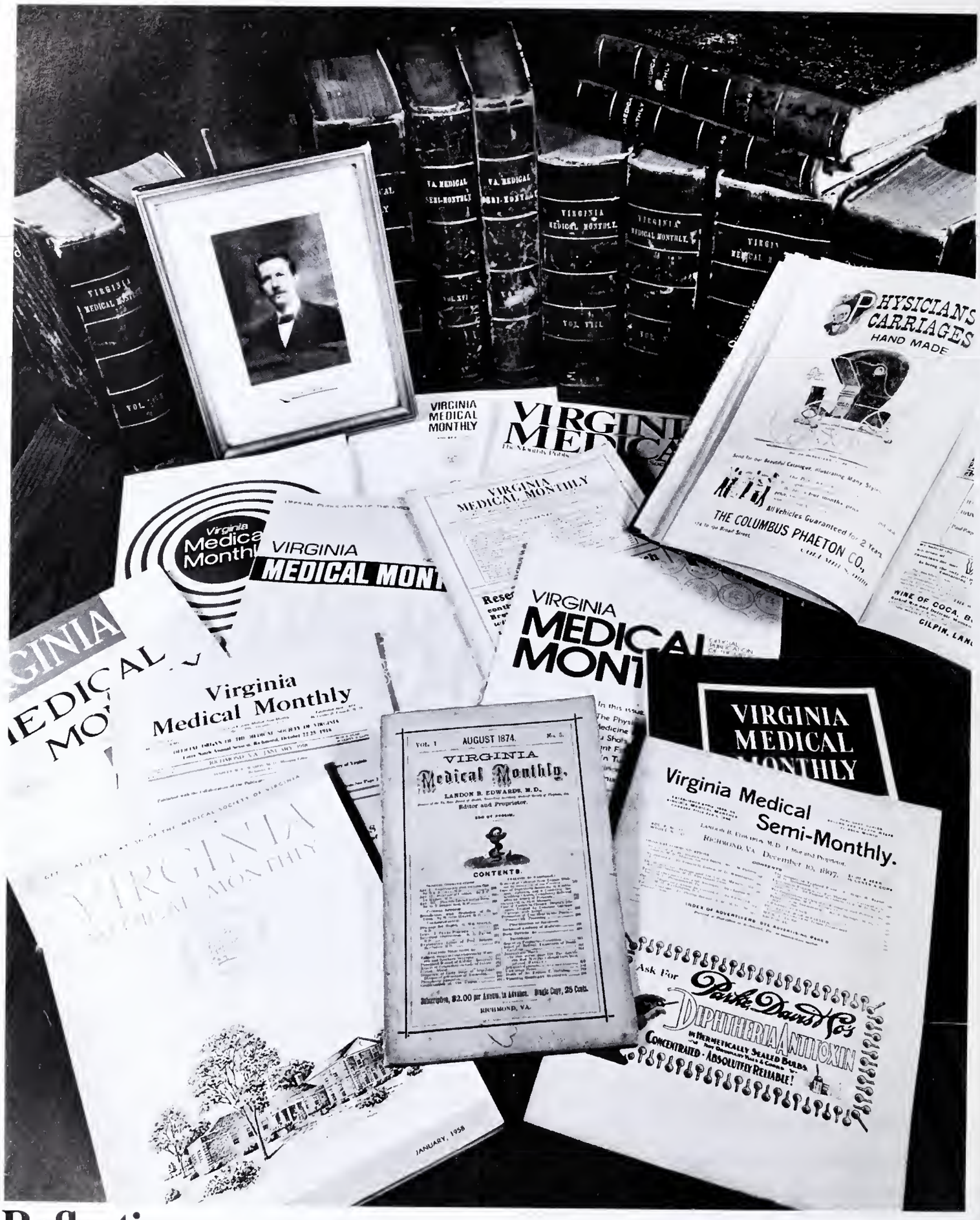

Reflecting its change to quarterly frequency, the Medical Society of Virginia's journal has a new name, VIRGINIA MEDICAL QUARTERLY, and a new cover logo to match. There have been many cover designs in the journal's 116-year history; some of them appear in the photograph above. But a name change happened only once before, when, for the years 1896-1918, it was a semi-monthly publication. Otherwise, the journal's formal name has been the one with which Founder Landon B. Edwards christened it in 1874. Dr. Edwards' picture appears in this photograph, leaning against some early bound volumes.

VIRGINIA MEDICAL QUARTERLY

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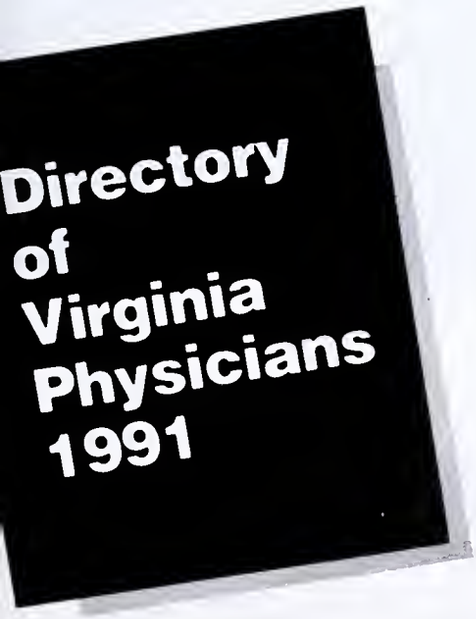

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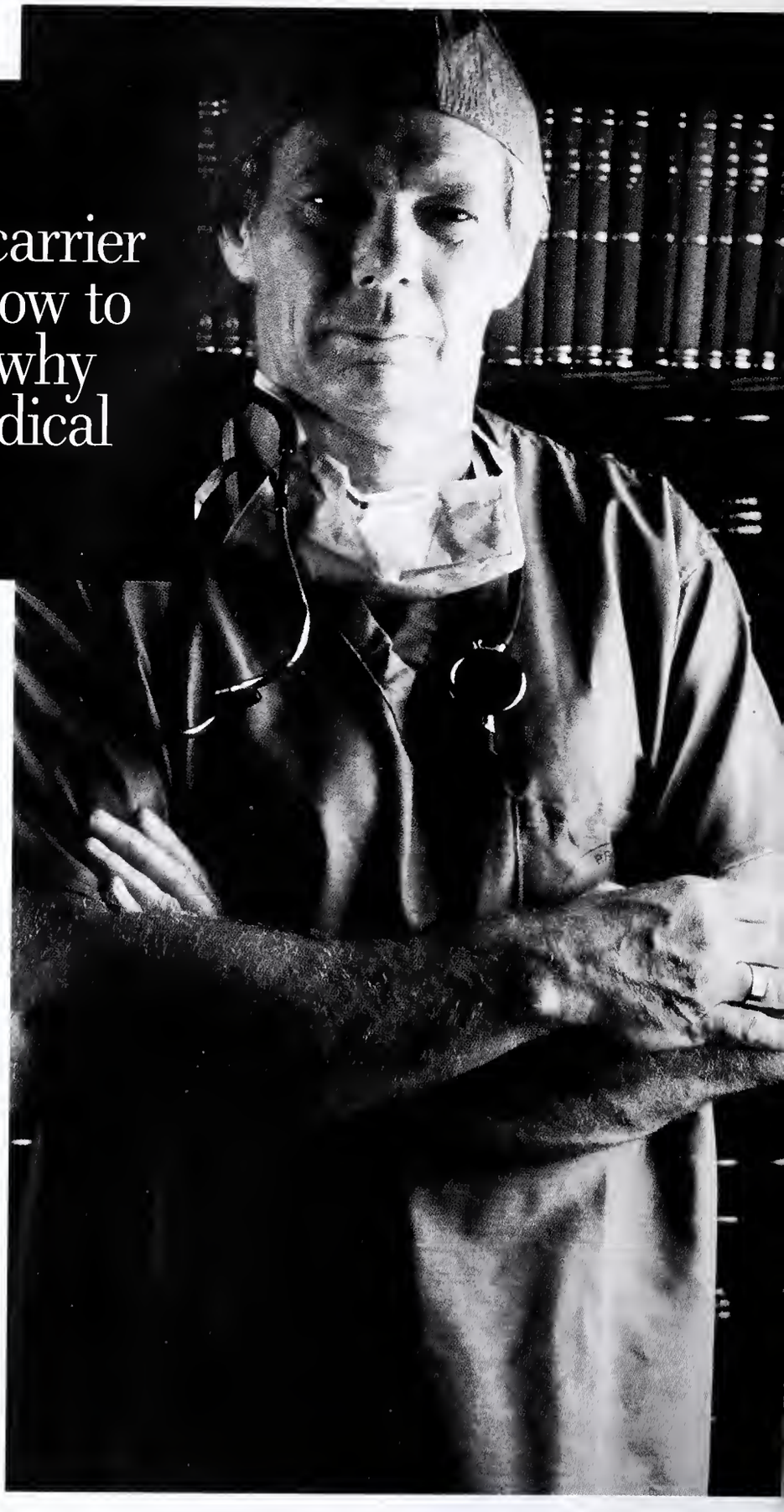

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"A Monstrous Intrusion"

Will National Data Bank Encourage Litigation?

The National Practitioner Data Bank, which became effective last month, is a monstrous intrusion on the civil liberties of physicians. (Thank heavens they don't have a data bank for lawyers.) On top of the outrageous insult to physicians' privacy,[1] achieved in the name of national peer review, the crazy thing is that the Data Bank may have the opposite effect of what is intended. My associates and I are already beginning to see this in our legal practice. Examples:

1. The Data Bank will discourage settlement of legal claims and encourage malpractice litigation.

While we do very little "insurance" work, we typically represent doctors in malpractice suits as their private counsel. Our job is to ensure that insurance counsel is doing the right things and, most importantly, to act as an advocate for the physician with his or her insurer. In the "old days," in cases with colorable claims we would often, as the doctor's private lawyers, urge an insurance company to settle a case. This would end the doctor's aggravation and protect him or her against possible recoveries in excess of insurance. The hope was we could also protect the doctor's rights against the insurance company if the company acted unreasonably in refusing to settle.

No longer. The Data Bank requires the reporting of any payment of settlement, irrespective of amount. That information is later available to insurers, hospitals, boards of medicine and, under certain conditions, plaintiff's attorneys. Now that the Virginia malpractice cap is solidified and assuming that my clients are properly insured to the cap, it would take a severe case indeed for me to urge a settlement. And nuisance settlements would be nuts.

The Data Bank's claim that "a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred" is. . . .well, ludicrous. If settlements don't necessarily mean anything, why is the Data Bank so intent on tracking them down to the last dollar? Is this akin to an F.B.I. "rap" sheet which lists all of a person's arrests and convictions?

The result of all this? Expect fewer settlements of malpractice claims and more litigation, more defense costs, and higher premiums.

2. The National Data Bank will discourage hospital peer review.

A motivating factor behind the Data Bank was to intensify peer review because of the "problem" (I personally don't see a problem) of incompetent doctors moving from one hospital to another and otherwise trying to hide their disastrous practice results from their colleagues. But several of my physician friends with responsible hospital peer review responsibilities have commented about their reluctance to engage in peer review activities which might end up in a doctor's Data Bank file. The perception is that this could "ruin" a physician. As a result, peer review activities will be kept at departmental levels, or be addressed orally or through private understandings. Such lack of formal structure is what led to the hullabaloo about ineffective peer review not too long ago.

Are my friends right, will a doctor reported to the Data Bank be ruined? Not necessarily, but 1) he or she might expect to deal with the local medical board about the matter (which might require counsel and which is expensive and aggravating); 2) the doctor might have problems with his or her insurance company; 3) he or she might have problems with every hospital in which the doctor has privileges or to which he or she wishes to apply.

3. The National Data Bank will encourage litigation against hospitals over privileges and might lower standards of medical practice.

Doctors who suffer a restriction or diminution of privileges are often required to take some sort of action, if feasible, because of the domino effect of such restrictions upon his or her privileges at hospitals elsewhere.

The Data Bank now also requires that doctors be reported if their request for upgraded privileges is denied (unless that denial relates to failure to meet general standards, like requirement for board certification). A physician who, for example, attends a course, learns a new procedure, duly applies for privileges to do that procedure and is rejected because, say, the department chairman didn't like the course, is reported to the Data Bank. Prior to the Data Bank era I might have advised such a physician to follow appropriate hospital channels and, if unsuccessful, forget about it. Now I'm not so sure. The rejection goes to the Data Bank. If that physician decides to apply for a medical license in the next state, the appropriate board of medicine will learn of the rejection. That will lead to a hearing, most probably, at the respective board's credentials committee, rather than a routine application approval.

What if it leads to a licensure rejection? (The Data Bank keeps track of licensure rejections, too.)

Will hospital doctors, knowing of these potential consequences, grant extensions of privileges that they might not otherwise entertain because of their empathy for the applicant who, if rejected, ends up in the Data Bank? Will this decrease the quality of medicine?

4. Professional societies will shy away from peer review. Many already do because of insurance problems. Now an adverse professional society action which affects membership must be reported to the Data Bank. While such reporting requirements have been in existence with respect to the Virginia Board of Medicine, my belief is that professional societies will be even more reluctant to take—and thus report—peer review type actions because of the intimidating presence of the Data Bank. After all, a physician who is expelled from a professional group for disciplinary reasons will likely sue to reverse the action because of the reporting to the National Data Bank. What professional society can function properly under that type of gun?

The Data Bank is a lawyer's delight. Lucky me. Unlucky us.

—John D. Grad

John Grad is counsel to the Alexandria Medical Society and a partner in the Alexandria law firm of Grad & Logan.

[1]The civil liberties implications of a national computer that keeps tabs on all things wrong, or arguably wrong, "perpetrated" by a select and suspect group of professionals, and which recognizes the "good works" of those who squeal on their colleagues, are obvious. Aside from the faulty underlying premise, the intrusion on privacy and discrimination against doctors as a class, I believe the Data Bank will be counterproductive. That is the thrust of these comments.

Fault/No Fault

Antidote for a Bad System: Rollovers and Easy Offers

You heard what those Yankee doctors in Massachusetts have got going in their legislature? A no-fault medical liability insurance bill.[1] Modeled after workers' comp, funded by 2% surcharge on health insurance policies, makes visions of big cuts in medical liability premiums dance through your head. The Massachusetts Medical Society engineered its introduction early last summer. Late in August I called the Society's headquarters in Boston to see if the bill was still alive.

"Yep, still alive," said the person who came to the phone.

Any bets the bill will pass?

Cheerfully: "Nope. The only bets have been that we wouldn't get it out of committee"—then, elated, "but we did it!" Joint Committee on Insurance was the one reported it out favorably. Next, when the senators come back from recess in mid-September, the Senate Ways and Means Committee. "We're pushing to get it to the floor of the Senate by October."

Amazing. Not limited no-fault, like Virginia's Injured Infant Act, but comprehensive, a whole new system. What, I wondered, does Jeffrey O'Connell think of that? Virginia's Mr. No-Fault.[2] Saw him not long ago at 4 am on the "Nightwatch" show bulldogging the biggest, orneriest plaintiff's lawyer you ever saw. I rang up the University of Virginia and asked for the John Allan Love Professor of Law. He answered the phone himself.

Yes, he knew of the bill. Innovative. Energetic. Lots of points for Mass Med Soc and its president, Dr. Barry Manuel, the bill's prime mover. "The present tort system is so bad. These people are trying to apply a more sensible system and that's encouraging."

But do you think it will pass?

Guardedly: "A very, very tough fight." As in all other states, the Massachusetts legislature is loaded with lawyers, many of them plaintiff's lawyers. Plus other special-interest groups circling a bill of this magnitude, waiting to pounce. "Very tough," O'Connell repeated. He sounded dubious.

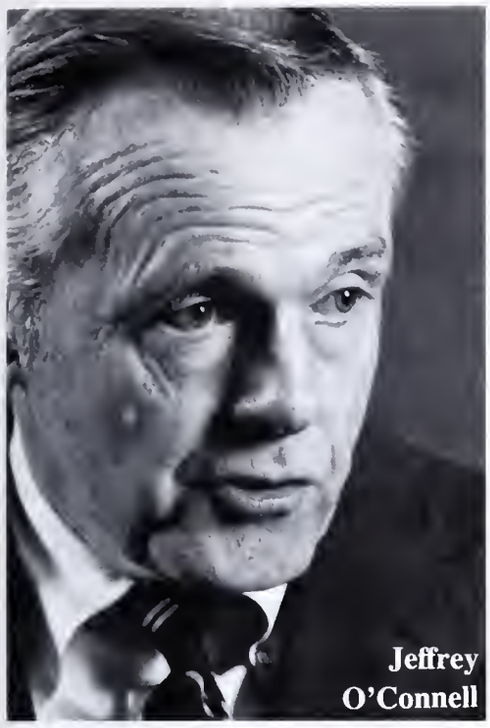
Well, how in the world does anyone get anything past the plaintiff's attorneys?

"You roll over 'em." Then, becoming animated, "You rolled over 'em right here in Virginia with the Injured Infant Act!"

Of course, there were a couple of helpful factors when that was passed, the Professor added. Liability insurance rates had gotten so terribly high, and liability suits had begun popping up in all manner of other professions and businesses and organizations, leading to a hue and cry about astronomical costs and an aroused public. Today, liability rates have subsided somewhat, liability suits are so pervasive they're commonplace, people are worried about other things, that makes it tougher, probably, to get past the plaintiff bar.

You like the Injured Infant Act?

"Well, we don't have any results yet, if that's what you mean, and we won't have results for five or six years more, so what it will achieve remains to be seen, and I will be a little nervous about it until we do. I like what the Act stands for—the


Jeffrey O'Connell

"You can tinker with the cap or with contingency fees or punitive damages or what have you all you like, but you've still got the same bad system."

first effort to carve out of the tort system a category of injury subject to terribly, terribly high awards. It is a worthy thing to try."

O'Connell is troubled by the 1990 General Assembly's revision of the Act's narrow definition of injury. "It is so hard to decide, in advance, just which victims deserve this limited kind of no-fault compensation and which ones don't, and then to define the ones who do and the ones who don't. I'm afraid we will be massaging this definition forever," he observed.

The 1990 Assembly considered massaging the cap, too, so that it would read $1 million per defendant, but carried the bill over.[3] Forecast, please?

"The cap is perceived as being very hard on the severely injured people." But, he pointed out, even if you alter the cap for these people, they still must go through the same long, arduous litigation process with no guarantee of anything in return.

"So you see, these kinds of revisions and extensions only play at the edges of addressing the real problem, which is that the present system is a very bad one and ought to be changed. You can tinker with the cap, with contingency fees or punitive damages or the collateral source rule or what have you all you like, but you've still got the same bad system.

"True, the cap that Virginia and other states put on pain and suffering may be one of the factors contributing to the recent stabilization of liability insurance rates, and the fact that rates have stabilized is good—though in point of fact it is relatively insignificant when you consider that they have stabilized at a level that a few years ago would have been intolerable and in many ways is still intolerable. We may have gotten used to them, but that doesn't lessen the fact that they are still very unmanageable."

His skepticism about working with the tort system extends to the new arbitration pilot program put together by a coalition of Virginia doctors, trial and defense lawyers, and insurance companies.

"All these things take so much effort," he said, "but they aren't really going to make a lot of difference as long as you've got the fault system. I would so much rather see all that effort getting behind a different system."

Like the limited no-fault Injured Infant Act?

"Yes. A new approach."

Like the no-fault bill in Massachusetts?

"An admirable effort."

Would you like to see The Medical Society of Virginia sponsor such a bill?

"The passage of the Injured Infant Act encourages me to think that Virginia is more receptive to change than in the past, but even so, I don't think the time is right for that sweeping a change here," O'Connell said.

"I would say, Go for the no-fault system, yes, but do it with a long view, 10 or 15 years, take it in small pieces, like the Injured Infant Act, like the no-fault immunization measure. We get reforms every once in a while."

And he just happened to have at the ready an idea for a small piece of reform he thinks has terrific possibilities. He calls it "Easy Offers,"[4] he describes it as a halfway house between the tort system and no-fault, and this, in brief, is the way it plays:

Within a certain period of time after a claim is filed, 90 days, maybe, or 180 days, the carrier offers to pay for all economic losses the patient alleges (including medical expenses). Thereupon one of two things follows. 1) Patient accepts, case is foreclosed, that's that. 2) Patient believes there's proof beyond reasonable doubt that provider acted "wantonly" (criminally), refuses offer, goes to court for high-dollar punitive damages. This scenario could apply broadly, to all claims, or narrowly, to one category of claim.

Would you recommend Easy Offers legislation as a next step in Virginia?

"I certainly would. Obstetrical cases would be the logical place to start. That's where the crisis is."

—Ann Gray

1. Larkin H. Massachusetts no-fault bill seeks system like workers' comp. Am Med News June 22, 1990, p 9
2. O'Connell J. The "neo no-fault" alternative. Va Med 1985;112:239-43
3. MSV Legislative Update 1990;3(3):4
4. O'Connell J. Pragmatic constraints on market approaches: a response to Professor Epstein. Va Law Rev 1988;74:1475-83

Photo of Jeffrey O'Connell for VMQ by Tom Cogill

Hewing to the CPT-4

How to Avoid a Medicare Postpayment Audit

A number of Virginia physicians have been jolted recently by audits conducted by the Travelers Insurance Company advising that Medicare disagrees with their selection of procedure codes for office and hospital visits. Physicians are being notified by an "educational" letter from the Medicare postpayment audit unit.

A typical notification from the Travelers advises that an audit of the physician's claims, payment history, and records for the past one or two years has been conducted by Medicare. The letter explains Medicare's evaluation of the physician's billing practices and requests that "such billing practices cease." The notice concludes with the admonition that continued abuse could result in exclusion from the Medicare program in accordance with Section 1862(d)(1) of the Social Security Act.

The abusive billing practice referred to is single-level procedure coding. Medicare requires that physician billing for consultations and for office, hospital and home visits conform to the American Medical Association Physicians' Current Procedural Terminology, Fourth Edition, 1990 (CPT-4). That coding scheme provides for multiple levels of service in the office, hospital and home. The levels range from minimal (e.g., blood pressure check by physician employee) to comprehensive (complete indepth evaluation and examination of the patient). CPT-4 provides five levels of service for initial consultations, new patient office visits, hospital care (subsequent to admission) and established patient home visits. Six levels of care are available for established patient office services.

Medicare audits are focusing on physicians who bill all or most visits at only one level of service. Medicare expects that a typical physician practice would include some patients requiring service only at the minimal or brief level; some needing intermediate, extended or comprehensive service; but the majority requiring limited levels of service. Physicians who, for example, routinely bill all hospital visits at the 90260 (intermediate) level create a billing pattern that appears aberrant to the Medicare postpayment analysis computer program. These physicians are selected for indepth audits which can result in issuance of the "educational" missive.

Although the first letter to a physician is indeed only educational, it certainly implies more drastic action in the future if the physician doesn't react to Medicare's suggestions. Medicare has at its disposal a variety of punitive measures, up to and including exclusion from the Medicare program. However, the usual Medicare procedure in this case is to conduct a followup audit within 6-18 months after the initial educational letter. If the billing pattern remains unaltered, Medicare reviews a random sample of physician records to determine how many services may have been "upcoded." Extrapolating this sample to the universe of claims for the period reviewed, Medicare calculates an overpayment and notifies the physician that he has 30 days to repay the entire amount. Such

MEDICARE CODING GUIDE

Services Performed	Minimal	Brief	Limited	Intermediate	Extended	Comprehensive
	1 of 2	3 of 4	4 of 6	5 of 7	8 of 11	10 of 13
Complaint/Symptoms		☐	☐	☐	☐	☐
Interval History			☐	☐	☐	☐
Details of Illness				☐	☐	☐
Review of Systems					☐	☐
Past History					☐	☐
Family History						☐
Blood Pressure	☐				☐	☐
Temperature						☐
Pulse					☐	☐
Limited Exam (One area)		☐	☐			
Limited Exam (Two or more areas)				☐	☐	
Complete Exam (Including pelvic)						☐
Lab/X-ray Review			☐	☐	☐	☐
Diagnosis/Problem		☐	☐	☐	☐	☐
Advice/Treatment/Injection	☐	☐	☐	☐	☐	☐
Office: New Patient		90000	90010	90015	90017	90020
Office: Established Patient	90030	90040	90050	90060	90070	90080
Hospital:		90240	90250	90260	90270	90280
Home: New Patient		90100	90110	90115	90117	
Home: Established Patient	90130	90140	90150	90160	90170	

overpayments for a year's worth of claims can easily run into many thousands of dollars.

Happily, physicians can easily avoid this somewhat unpleasant encounter with Medicare's enforcement unit. The most important first step is to become familiar with the Definitions and Items of Commonality section in the CPT-4 Introduction (pp 19-26). In conducting its audits of patient charts and hospital records, Medicare looks for documentation that the level of service billed is consistent with the code described in CPT-4.

Following a patient encounter, the physician should indicate on the patient chart (or checkoff form) the level of service code commensurate with the service actually performed. In some practices, this responsibility is delegated to a coding or billing specialist. That person should be familiar with the CPT-4 definitions and the necessity to utilize all levels of service when appropriate.

Physicians may also want to utilize the accompanying chart as a quick reference source when selecting the appropriate coding level.

DAVID J. LATHAM, JD

Attorney Latham is associated with the law firm of Grad & Logan, PC, Alexandria, concentrating on health-care reimbursement and medical/legal issues. Address correspondence to him at 9702 Gayton Road, # 220, Richmond VA 23233.

Submitted 6-4-90.

New: Physician's Guide to Durable Power of Attorney for Health Care

A second legal instrument in the surrogate decision-making category has been enabled by Virginia's General Assembly (Va Code §37.1-134). It is the "durable power of attorney for health care," a variation on the classic legal document for financial affairs. This new instrument differs from the familiar Natural Death Act declaration in a highly significant way: It is not limited to terminal situations.

There are other important differences as well, and the Editors commissioned the Medical Society of Virginia's counsel, Sandra L. Kramer, to develop a *Physician's Guide to Durable Power of Attorney for Health Care*. This guide tells you exactly what to look for and how to handle this new document. With it you will receive a sample form for executing a durable power of attorney for health care. *Guide* and form are offered to you here free of charge.

Many attorneys suggest executing both a durable power of attorney for health care and the Natural Death Act declaration form, and some of your patients may do so. Requests for the latter form, which Va Med has been sending out since 1983, took a terrific leap upward after the U.S. Supreme Court's decision in the Cruzan case. There are plenty of copies on hand for your patients, and copies are available as well of the companion piece, the *Physician's Guide to the Natural Death Act*. Both are free of charge.

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Patient Access to Medical Records:

Answers to Ten Common Questions

1 What exactly do "medical records" include? Should I include billing records? How about medical records prepared by other physicians or health facilities?

The Virginia Public Records Act defines "medical records" as "the documentation of health care services, whether physical or mental, rendered by direct or indirect patient-provider interaction, which is used as a mechanism for tracking the patient's health care status." This Act applies to records in the custody of public agencies and is not directly applicable to records held by private physicians, but it gives some indication of the scope of the term. Billing records would not appear to fall within this definition, but medical records prepared by another physician might well be included.

2 What rights does a patient have to his or her medical records?

Virginia law provides that upon written request, patients are entitled to copies of their medical records within 15 days at a reasonable charge. This right is enforceable by a subpoena issued by the court.

3 Can I refuse to give a patient with an outstanding bill access to his or her records?

No. Virginia law provides that a patient must be furnished with copies of his or her medical records on request and does not provide an exception for patients with outstanding bills.

4 Are there any limitations on patients' access to their medical records?

Virginia law provides that mental records which are official records may not be reviewed by a patient if the treating physician has made a part of these records a written statement of his opinion that a review of such records by the patient would be injurious to the patient's physical or mental well-being. The same pertains when a patient requests copies of mental records, although in the case of copies, the physician may be required to give the records to the patient's attorney.

5 Can I bill for the copying costs? If so, is there a specified charge?

Yes. As currently written, Virginia law provides that "a reasonable charge, not to exceed 50¢ per page," may be made for such copies. However, on the initiative of the State Legislative Committee, the Medical Society of Virginia intends to ask the 1991 General Assembly to rewrite the passage so that not only photocopying but associated costs, such as research, are chargeable.

6 Can I refuse a minor patient's parents, who pay for the treatment, access to the medical records of that patient?

Virginia law does not address this issue directly. However, minors are deemed adults for purposes of consenting to medical services in connection with 1) venereal or infectious diseases which must be reported to the State Board of Health; 2) birth control, pregnancy, or family planning; 3) mental illness; and 4) substance abuse. Physicians may have a duty of confidentiality to minor patients who can give consent to treatment. If so, the relevant records should not be released without the authorization of the minor's parents.

7 What if I no longer have the requested records?

You should so inform the patient, and if you know where the records may be found, you may want to tell the patient. Virginia law provides that a patient may seek a subpoena to force a physician to deliver copies of medical records and provides that a court may impose damages, including costs and attorney's fees, upon a physician who willfully or arbitrarily refuses to provide them. If you have exerted your best efforts and cannot obtain the records, then you should not be penalized.

8 Should I transfer original medical records?

Virginia law does not address this issue. The common law indicates that original medical records are the property of the physician who created and maintains them, but a patient has an interest in the information in the records. The prudent course would be to retain the original records and transfer copies.

9 Who can sign an authorization for records release?

Virginia law does not address this issue. The common law indicates that a patient may authorize the release of his or her records or, if the patient is incompetent, his or her guardian may do so.

10 Who can get access to a deceased, incapacitated, or incompetent patient's records?

These records should be provided on request to the following persons in the following order of priority: 1) the personal representative of a deceased patient; 2) the legal guardian or committee of an incompetent or incapacitated patient; 3) the spouse; 4) an adult son or daughter; 5) either parent; 6) an adult brother or sister; 7) any of the other relatives of the patient in the descending order of blood relationship. Physicians are required to provide these records only if they are not aware of any available person with a higher priority.

—Timothy A. Hartin

Some of the answers above are based on Virginia statutes; others are interpretations of the case law in other jurisdictions. Physicians are encouraged to contact their attorneys for more specific guidance.

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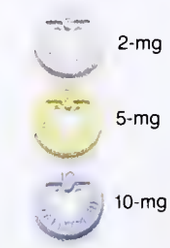

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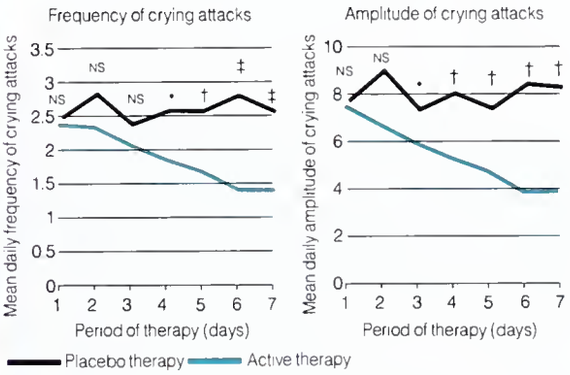

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Liver Transplantation in Virginia

Mitchell L. Shiffman, MD, Marc P. Posner, MD, Velimir Luketic, MD, A. Scott Mills, MD, Wallace Berman, MD, Ann Whitman, RN, H. M. Lee, MD, and Robert L. Carithers, Jr., MD, *Richmond, Virginia*

Survival rates ranging from 70-80% have been documented over the past three years in liver transplant patients at the Medical College of Virginia. Survival declined in patients with numerous complications of chronic liver disease and with significant deterioration in hepatic synthetic function. Early referral was a major factor contributing to survival.

LIVER transplantation is now well accepted as an effective long-term treatment for patients with end-stage liver disease. In Virginia, liver transplantation began in earnest at the Medical College of Virginia (MCV) in January 1984. Since then over 100 transplants have been performed in 82 adults and 13 children. Overall, one-year patient survival during the past three years has ranged between 70-80%, equivalent to that reported by other centers.[1,2]

Four years ago we reviewed the history of liver transplantation and the early results of our program for VIRGINIA MEDICAL.[3] The present article is designed for the practitioner and specialist caring for patients with liver disease in Virginia and the surrounding region. Key issues regarding referral of patients for liver transplant evaluation are discussed as are some of the long-term complications associated with hepatic transplantation. These issues are of major concern to referring physicians who share the burden for the future care of these patients.

From the Division of Gastroenterology, Section of Hepatology (Drs. Shiffman and Luketic), the Division of Vascular and Transplant Surgery (Drs. Posner and Lee and Nurse Whitman), and the Departments of Pathology (Dr. Mills) and Pediatrics (Dr. Berman), Medical College of Virginia/Virginia Commonwealth University. Dr. Carithers is now with the University of Washington School of Medicine at Seattle. Address correspondence to Dr. Shiffman at Box 711, MCV Station, Richmond, VA 23298.

Submitted 3-22-90.

The Team

The complex and multiple issues and disciplines required to adequately care for patients with chronic liver disease in need of hepatic transplantation demands a team approach. This philosophy is shared by many other transplant centers and the essential personnel for such an endeavor was discussed in a recent review.[4] At MCV the liver transplant program is guided by a multidisciplinary committee which meets on a regular basis to discuss the pre-, intra-, peri-, and post-transplant needs of each patient. This committee is composed of key personnel from the transplant team, which includes not only transplant surgeons and dedicated anesthesiologists but also transplant hepatologists, critical care/pulmonary specialists, a liver pathologist, blood banking specialists, a social worker, psychologist, a hospital clergy representative and the liver transplant nurse coordinator. The roles that many of these specialists play in the transplant process are discussed below.

At MCV, as in most other successful programs, the

transplant hepatologist serves as the referral agent for the practicing physician and directs the pretransplant evaluation to determine if the patient is a suitable candidate for transplantation. Since most patients do not require emergent transplantation after their evaluation the hepatologist also works closely with primary referring physicians to manage the complex medical care that patients with chronic liver disease require prior to their transplant. During this waiting period, which may last anywhere from days to months, the progress of each patient is closely followed by the interdisciplinary transplant committee.

The transplant surgeon is the leader of the surgical team and is notified whenever a potential donor organ becomes available. He must then decide which patient on the active waiting list is the most appropriate candidate to receive this organ. Four major criterion are utilized to match a donor liver to a potential recipient: 1) ABO blood group compatibility, 2) body size of donor and recipient, 3) the recipient's overall clinical condition, and 4) the quality of the donor organ. The blood bank is then contacted to ensure that an adequate supply of blood products is available to support the operation, and arrangements to retrieve the organ and have it transported to MCV are made. In most cases this requires the surgeon to travel long distances by corporate jet, harvest the organ and then return to MCV prior to starting the transplant operation. However, if an experienced transplant surgeon is on staff at the donor hospital, arrangements can be made for this surgeon to remove the organ and have it sent to MCV on ice. Such arrangements are becoming increasingly common throughout the country as the number of trained transplant surgeons increases. In addition, the development of a new preservative (University of Wisconsin solution) has increased the amount of time a liver can be stored to nearly 24 hours,[5] enabling the surgical team time to rest and refresh themselves between harvesting and transplanting operations.

The transplant operation itself is a tedious and complex process taking from 6-18 hours and requiring large amounts of blood products. We and others have described this procedure in recent reviews.[3,6,7]

Following the transplant operation the patient is moved to the medical intensive care unit and cared for by a team of intensive care unit/pulmonary specialists and the transplant hepatologist, all under the overall direction of the transplant surgeon. The patient remains in this unit until clinically stable, typically 5-10 days, before being transferred to the Clinical Transplant Center. The patient remains in this specialized nursing unit anywhere from 2-4 weeks, until ready for hospital discharge.

Following hospital discharge the hepatologist and liver transplant nurse coordinator assist referring physicians with post-transplant followup, and regularly monitor blood cyclosporin levels and liver function tests. Liver biopsies are performed at regular intervals and/or whenever necessary to investigate fluctuations in serum tests of liver function.

A highly skilled pathologist interested and experienced in liver disease is an essential member of any successful liver transplant program. This individual interprets pre-transplant liver biopsies, evaluates the explanted recipient liver for signs of occult carcinoma, and interprets all biopsies from the transplanted allograft. Although hepatic allograft rejection is frequently associated with elevations in serum liver transaminases (AST and ALT) this diagnosis can only be confirmed by histologic examination of the liver. Since this histologic picture is often quite subtle it requires both skill and experience to be confident of this diagnosis. This distinction is critical since rejection is treated with large doses of potentially toxic immunosuppressive agents.

The clinical nurse coordinator is the primary contact person for patients and their families, with input into nearly every aspect of patient care. The nurse schedules the initial transplant evaluation, orients patients and their families to the transplant center, and educates patients about such issues as the transplant process, immunosuppression, side-effects of drugs, and post-operative complications. Following transplantation the nurse coordinator monitors scheduled blood tests and cyclosporine levels, reviews these with transplant physicians, and schedules any necessary tests or biopsies to investigate laboratory abnormalities. Without a doubt, an effective nurse coordinator may be the most important asset to any transplant program.

Indications/Contraindications

Indications for liver transplantation include chronic or acute liver failure of any etiology. A list of the most frequent diagnoses for patients undergoing liver transplantation throughout the country are listed in Table 1. In addition, several genetic diseases which manifest their deleterious effects via the liver can be cured by hepatic transplantation. Such diseases include homozygous type II hyperlipidemia, hemophilia (homozygous factor VIII deficiency), alpha-1-anti-trypsin deficiency, glycogen storage diseases, and certain types of porphyria, to name a few. Table 2 lists the percentage of liver transplants performed at MCV during the past six years according to liver disease etiology. Special considerations for several of these are discussed below.

Only five absolute contraindications to liver transplantation currently exist: 1) acquired immunodeficiency syndrome (AIDS); 2) active sepsis outside the hepatobiliary tract; 3) cholangiolar carcinoma; 4) advanced cardiopulmonary disease; and 5) metastatic cancer.[1,3] Chronological age is no longer an important factor as long as the patient has no significant underlying cardiopulmonary complications. The oldest pa-

tient transplanted at MCV is now 66 years of age and continues to do well three years after his operation.

Alcoholic Liver Disease. Clearly, the most debatable indication for liver transplantation is alcoholic liver disease. Many transplant centers require that patients be abstinent for at least six months prior to undergoing transplantation. However, this approach has been challenged by Starzl and his colleagues from Pittsburgh, who reported that patients with alcoholic liver disease had a one-year survival of 73%, no different than that observed for other liver diseases.[8] Only one of these patients returned to alcoholism despite the fact that none were given any formal counselling or treatment for their disease.

At MCV 7% of our patients have undergone transplantation for alcoholic liver disease. To our knowledge none has returned to drinking alcohol. We do not discourage the referral of patients with alcoholic liver disease for transplantation and assess each patient on an individual basis. However, we do insist that patients are abstinent for at least six months, and we strongly encourage them to participate in a formal counselling program prior to transplantation.

Our major concern about transplanting patients with alcoholic liver disease is the presence of underlying but clinically undetectable extrahepatic manifestations of chronic alcoholism, such as cardiomyopathy and neuropathy. Indeed, 50% of our patients transplanted for alcoholic cirrhosis have sustained an episode of acute cardiac decompensation anywhere from three days to 12 weeks following their transplant despite a normal pre-operative cardiac evaluation.

Hepatic Malignancies. The risk of hepatocellular carcinoma (HCC) in patients with underlying cirrhosis is significantly higher than that observed in the general population. As a result, it is not unusual to find a small incidental HCC after a cirrhotic liver has been removed and thoroughly examined. In the Pittsburgh experience 14 patients had tumors found in such a manner. Of these, only one had recurrent disease after 3-73 months of followup.[9] At MCV, such "incidental" hepatomas have been found in two patients (2.5%) following removal and careful inspection of their cirrhotic liver. Both are still alive without evidence of metastatic disease up to three years following transplant.

In contrast to the incidental tumor, liver transplantation specifically for known unresectable HCC has produced disappointing results. Ninety percent of patients had recurrent tumor within two years of transplantation.[9] At MCV we have performed one transplant for unresectable hepatoma. Despite a pretransplant laparotomy, no sign of metastatic disease at the time of transplantation, and histologic evidence that the tumor was confined within the capsule when removed, recurrent HCC appeared within one year. Thus we are reluctant to perform transplantation for unresectable primary liver cancer, especially with the scarcity of donor organs.

Cholangiocarcinoma is a particularly distressing problem. Not only can this tumor masquerade as sclerosing cholangitis, but 12-15% of patients transplanted for well-documented sclerosing cholangitis are

Table 1. Common Indications for Liver Transplantation.

Chronic hepatocellular liver diseases
- Chronic viral hepatitis (B, C and B + D)
- Autoimmune chronic active hepatitis
- Alcoholic liver disease
- α-1-antitrypsin deficiency
- Congenital hepatic fibrosis
- Cryptogenic cirrhosis
- Hemochromatosis (unresponsive to phlebotomy)
- Wilson's disease (unresponsive to penicillamine)

Chronic cholestatic liver diseases
- Primary biliary cirrhosis
- Sclerosing cholangitis
- Secondary biliary cirrhosis
- Caroli's syndrome
- Biliary Atresia

Vascular diseases
- Budd-Chiari syndrome
- Veno-occlusive disease

Fulminant Liver Failure
- Viral hepatitis (B, C, B + D)
- Wilson's disease
- Drug or toxin induced

Inherited Metabolic Diseases
- Hemophilia A
- Homozygous familial hyperlipidemia
- Tyrosinemia
- Glycogen storage diseases
- Protoporphyria

Table 2. Etiology of Liver Disease in 136 Adults and 23 Children Evaluated January 1984-February 1990.

Adults	% of Total Pts Evaluated	% of Total Pts Transplanted*
Chronic active hepatitis	21%	18%
Primary biliary cirrhosis	17%	18%
Sclerosing cholangitis	12%	16%
Chronic hepatitis B	11%	11%
Cryptogenic cirrhosis	11%	10%
Alcoholic cirrhosis	5%	7%
Post-transfusion chronic non-A, non-B hepatitis (probably hepatitis C)	5%	5%
α-1-antitrypsin deficiency	4%	3%
Fulminant hepatic failure	4%	3%
Primary graft failure	2.5%	3%
Hemochromatosis	2.5%	1%
Cholangiocarcinoma	1.5%	2%
Tylenol overdose	1.5%	0%
Hepatocellular carcinoma	<1%	1%
Chronic hepatitis D	<1%	1%
Bile duct breakdown Requiring retransplantation	<1%	1%
Children		
Biliary atresia	61%	69%
α-1-antitrypsin deficiency	9%	15%
Neonatal hepatitis	9%	8%
Choledochal cyst	4%	0%
Tyrosinemia	4%	0%
Chronic active hepatitis	4%	8%
CMV hepatitis	4%	0%

* Total number of patients transplanted: 82 adults, 13 children

found to have cholangiocarcinoma after their liver is removed and carefully inspected.[9] Unfortunately, the prognosis for each is poor. All patients with any evidence of cholangiocarcinoma at transplantation typically develop metastatic disease and do not survive beyond two years. Our experience is similar to that reported by other transplant centers. Of patients transplanted at MCV for presumed sclerosing cholangitis 2/12 (14%) were found to have had cholangiocarcinoma throughout the liver. An additional 7% of patients were found to have incidental cholangiocarcinoma in association with sclerosing cholangitis. All but one of these patients subsequently died or developed metastatic disease within one year of transplant. Our current feeling is that patients with well-documented sclerosing cholangitis should be transplanted early in their course and that the entire recipient common bile duct be resected.

Chronic Hepatitis B Infection. All patients transplanted for chronic hepatitis B virus (HBV) infection develop reinfection of their donor organ and remain chronic carriers of HBV. Treatment with large quantities of hepatitis B immune globulin and/or immunization against HBV immediately prior to and at the time of transplantation does not prevent reinfection.[6] However, the clinical course of these patients remains highly variable. Although some develop aggressive chronic active hepatitis and cirrhosis, many simply remain asymptomatic carriers of HBV. Of the patients with chronic HBV infection transplanted at MCV, 50% have developed cirrhosis. Despite this, we continue to evaluate and transplant persons with cirrhosis and chronic HBV infection but fully explain the risk of recurrent disease. The use of new treatments for HBV infection, such as alpha-interferon administered weeks to months prior to transplantation, may reduce the rate of recurrent HBV infection in the future.

Fulminant Hepatic Failure. Transplantation for patients with fulminant hepatitis is often a "catch-22." Spontaneous survival rates for patients with stage I or II encephalopathy are good. Transplantation at these stages is rarely necessary and would leave a foreign organ in a patient who would have otherwise recovered. In contrast, if one waits until the patient is in stage IV coma, where survival is less than 10%, brain death is common, despite successful transplantation. The timing for transplantation is even more difficult since the rate of deterioration from stage II-IV encephalopathy may occur within hours. As a result, a donor organ is often not available in time to save the patient. Over the past four years eight patients with fulminant hepatic failure have been evaluated for emergent transplantation at MCV. Four recovered spontaneously, two reached stage IV coma and died before a donor organ could be obtained, and two patients underwent transplantation. Unfortunately, the timing was not adequate and both suffered irreversible neurologic damage in spite of well-functioning allografts. Thus we and others[10] feel that the best results for patients with fulminant hepatic failure will be achieved only by early referral to a transplant center for continuous neurologic monitoring with transplantation at the first sign of deterioration.

Referral of Patients

Early referral of patients with known chronic liver disease for transplant evaluation is one of the most important predictors for a successful outcome. Waiting until patients with chronic liver disease develop signs of hepatic decompensation severely restricts their ability to survive the waiting period and surgical procedure. In addition, patients referred late in their disease are also at increased risk for post-operative complications and have a longer post-operative hospitalization. Such complications significantly increase medical costs and decrease patient survival. Two large series have clearly documented that survival approaches 90% when patients are referred for transplant evaluation early in their course and transplanted when relatively healthy, rather than after complications have occurred and patients begin to deteriorate.[1,2] In contrast, transplantation on an emergent basis reduces survival to less than 25%.

These same trends have been observed in our program. Long-term survivors of liver transplantation at MCV had slightly better overall hepatic function at the time of evaluation as determined by serum bilirubin, albumin and pro-time compared to persons who died (Table 3). Of critical importance, however, was that patients who died before a donor organ could be found had significant increases in serum bilirubin and prothrombin time, a lower plasma albumin, and significant increases in the number of major complications associated with chronic liver disease, i.e., variceal bleeding, ascites and spontaneous bacterial peritonitis (SBP), compared to patients who survived long enough to undergo transplantation, regardless of out-

Table 3. Clinical and Laboratory Features of Patients at Time of Liver Transplant Evaluation and Outcomes, January 1984-February 1990.

	Long-Term Survival	Died Post-Transplant	Died Pre-Transplant
Number of Patients	58	24	25
Clinical Features			
Variceal bleeding	26%	14%	76%*†
Ascites	74%	56%	68%
SBP	22%	14%	50%*†
Hepatic encephalopathy	32%	46%	76%
Laboratory Values			
Bilirubin (mg/dl)	9.4 ± 0.5	16.0 ± 3.1	18.3 ± 3.1*
Albumin (mg/dl)	3.1 ± 0.1	3.0 ± 0.1	2.9 ± 0.1
PT (seconds)	14.8 ± 0.2	16.1 ± 0.8	18.4 ± 0.9*†

Values are given as mean ± SE.
SBP: spontaneous bacterial peritonitis.
PT: Prothrombin time.
* Significantly different than for long-term survivors; $p < .05$.
† Significantly different than for patients who died following transplantation; $p < .05$

come (Table 3). This suggests that these patients were referred for transplantation far too late in their course and had little hepatic reserve to survive the evaluation and waiting process.

It is therefore apparent that patients with chronic or fulminant hepatic disease should be referred for liver transplant evaluation at the first sign of hepatic compromise, if not sooner. A list of the symptoms we consider to be ominous signs of progressive liver disease and which should prompt evaluation are listed in Table 4. Even the slightest abnormality in hepatic synthetic dysfunction in patients with known chronic liver disease is important. Subtle declines in serum albumin and the development of a mild coagulopathy are often the first signs of hepatic decompensation. However, these signs are frequently overlooked until more dramatic complications appear. Indeed, the higher incidence of bleeding, ascites and SBP observed in patients who survived transplantation compared to patients who died following this procedure reflects their referral earlier in the course of their disease. Although patients who died following transplantation had less complications, their hepatic function (based upon measurements of bilirubin, albumin and prothrombin time) was more severe (Table 3). Since the natural course of end-stage liver disease is highly variable and unpredictable, the benefits of early referral for transplant evaluation are therefore apparent.

Table 4. Indications for Liver Transplant Evaluation.

Chronic Liver Disease
First appearance of ascites
First episode of encephalopathy
First variceal bleed
Hyponatremia (serum sodium <130 mM)
Any evidence of hepatic synthetic dysfunction
Hypoalbuminemia (albumin <normal)
Prothrombin time ≥2 seconds than control
Fulminant Liver Failure
First appearance of encephalopathy
Prothrombin time ≥4 seconds over control without correction
Bilirubin >10 mg/dl
Serum creatinine >2.0
Serum albumin <3.5

The evaluation procedure itself is fairly straightforward and is designed to answer four basic questions: 1) Can the patient tolerate a transplant operation? 2) What does the hepatic vasculature look like? 3) Has a treatable cause of this patient's liver disease been overlooked? 4) Is the patient psychologically, emotionally and financially able to undergo this procedure? The patient is evaluated for underlying cardiac, pulmonary and renal disease. A hepatic angiogram is performed to evaluate the hepatic artery and portal vein for anomalies and patency. If not done so previously, all screening tests for treatable causes of chronic active hepatitis are performed as well as a liver biopsy if not contraindicated by the presence of a coagulopathy and/or thrombocytopenia. The complete list of tests included in our pre-transplant evaluation are listed in Table 5.

Table 5. Tests in Liver Transplant Evaluation.

Etiology of Liver Disease: ceruloplasm, ferritin, transferrin, AMA, anti-smooth muscle antibody; anti-mitochondrial antibody, α-1-antitrypsin level, serologies for Hepatitis B (sAgm sAb, cAb), C (Ab), D (Ab if pt HBV+); liver biopsy (evaluation of any previous biopsies; if previous biopsy not available and not contraindicated by coagulopathy and/or thrombocytopenia).
Cardiovascular System: persantine or stress-thallium test; cardiac catheterization (if P-thallium test + or age >55 yrs); ECHO cardiogram; EKG.
Pulmonary System: pulmonary function tests; arterial blood gas.
Hepatic Blood Supply: ultrasound with duplex scanning; mesenteric angiogram.
Renal Function: Serum BUN and creatinine; 24-hr urine for creatinine clearance.
Psychosocial: psychological evaluation, evaluation of health insurance coverage and copayments.

With early referral, many patients with chronic liver disease will not be either medically or physically ready for transplantation following their evaluation. This is actually the optimal situation. Once the evaluation is complete patients can be comfortably but closely followed by their referring physician with periodic input from the transplant hepatologist. The patient can then be moved to the active transplant waiting list at the first hint of further decline.

Early referral for transplant evaluation also gives the patient time to adapt psychologically to the realization of this procedure, to tour our facilities, and to meet other patients who have undergone hepatic transplantation through our program. It is equally important that patients have time to assess the financial impact that this procedure might have on their family and/or to raise money in order to afford this operation. This later point is particular important and is discussed further below.

Long-Term Complications

Of the long-term complications of liver transplantation discussed in our recent review,[11] we discuss here three major long-term concerns to patients and referring physicians: rejection of the donor organ, recurrence of chronic liver disease, and the risks of life-long immunosuppression.

Allograft Rejection. Approximately 75% of patients will experience a mild rejection episode within 2-4 weeks of transplant. Although this is suggested by elevations in bilirubin, AST and ALT, and an abrupt decline in bile production,[12] allograft rejection can only be diagnosed by liver biopsy. The histologic features of rejection include portal inflammation with a mixed mononuclear/polymorphonuclear leukocyte infiltrate, erosion and destruction of small bile ducts and lymphocytic invasion of portal and central venous endothelium.[11]

In the outpatient setting acute rejection should be suspected in patients with flu-like symptoms, fever, malaise, and mild increases in AST, ALT and bilirubin. Most liver transplant recipients have a normal liver profile. Thus any elevation in blood chemistries may be significant. However, since both the clinical and laboratory features of rejection are non-specific and treatment with high dose immunosuppressive medication is not entirely benign, a liver biopsy must be performed prior to treatment in every case. Therefore all patients with suspected rejection should return to the transplant center for liver biopsy and treatment if necessary.

Chronic rejection is characterized by bile duct drop-out and is frequently referred to as the "vanishing bile duct syndrome." This condition is typically preceded by an episode of acute rejection which never fully responds to treatment. It is associated with chronic elevations in serum AST, ALT and bilirubin, is progressive, irreversible and eventually requires retransplantation.[11] Although the incidence of chronic rejection is reported to be 10%, we have not seen this in any of our patients treated with our current triple drug immunosuppressive regimen (see below).

Recurrence of Chronic Liver Disease. As noted above, all patients with chronic hepatitis B virus develop recurrent infection in the new liver. The majority of patients progress to cirrhosis, although the clinical course of post-transplant hepatitis B is highly variable.

Recurrence of other types of chronic liver diseases following transplantation is controversial. Recent case reports have suggested that both primary biliary cirrhosis[13] and sclerosing cholangitis[14] recur following transplantation. However, the histological and radiologic findings in these cases were also consistent with chronic rejection and/or ischemic injury to the donor organ.

Immunosuppression. Since 1986, all of our patients have been treated with "low dose" triple immunosuppressive therapy consisting of prednisone, azathioprine and cyclosporine. Cyclosporine has revolutionized liver transplantation and is singularly responsible for the improvement in long-term survival observed during the past decade. This agent, however, is also quite toxic and has a narrow therapeutic window.

The most predictable side effects of cyclosporin are hypertension and nephrotoxicity, although many other side effects ranging from neurotoxicity to hepatotoxicity have been reported.[6] Renal insufficiency has developed in 55% of our patients and 86% require antihypertensive medication. For treatment we use a variety of agents but usually avoid diuretics, since this may exacerbate renal insufficiency.

Several different assays are available to monitor cyclosporin levels. However, marked intra- and inter-assay variation make it very difficult to interpret cyclosporin levels from different laboratories. Thus our patients mail blood samples drawn by their hometown physicians to our laboratory for cyclosporine determinations. Doses are then adjusted by phone as needed. Such close monitoring of cyclosporine levels by a single laboratory coupled with the use of two other immunosuppressive medications may explain why we have not seen chronic rejection in any of our patients during the past four years.

Long-term immunosuppression also carries with it a continued risk of serious bacterial, fungal and viral infections. Minor influenza infections appear to be as common as seen in the general population, although resolution of flu-like symptoms seems to take longer. The most common troubling viral infections include cytomegalovirus and herpes viruses. Both can cause elevations in serum AST, ALT and bilirubin, and liver biopsy is frequently required to ensure that rejection is not present. Both respond to appropriate anti-viral therapy, gancyclovir and acyclovir respectively.

The increased incidence of malignancy in chronically immunosuppressed patients is also a major concern and includes carcinoma of the skin and lip, lymphoma and Kaposi's sarcoma. In our program one patient has developed skin cancer two years after transplantation.

Financial Considerations

The cost of liver transplantation is substantial, ranging from $100,000 to $250,000 or more. This figure is affected by the patient's overall clinical condition at the time of transplantation, which influences the risk of post-operative complications and the length of hospital stay. These enormous costs can threaten the financial stability of almost any family. Fortunately, most major insurance carriers now recognize the benefits of hepatic transplantation and pay at least a portion of these costs. To assist the patient with these complex financial considerations and to define the remaining financial obligation each patient will incur, a hospital financial administrator negotiates with the insurance carrier on behalf of each patient at the time of the transplant evaluation. With the help of such negotiations approximately 20% of our patients have discovered that their medical insurance fell short of their expectations and have had to raise money before a transplant operation could be performed. This is another reason why early referral is important.

Liver transplantation has recently been recognized by Medicare as an acceptable form of treatment for chronic liver disease and will soon be covered by this program. Thus lack of medical insurance is no longer an excuse for not referring an otherwise excellent candidate for transplant evaluation.

Summary

Over 100 liver transplant procedures have been performed at the Medical College of Virginia since 1984. Overall survival has ranged from 70-80% during

the past three years. Survival declines considerably in persons who have had numerous complications of chronic liver disease, and with significant deterioration in hepatic synthetic function. The single most important factor in determining patient survival is early referral of patients with chronic liver disease for transplant evaluation. Proper timing for transplantation can then be determined by the transplant team working in close association with the patient's referring physician.

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Mapping Out Skin Cancer: Mohs Micrographic Surgery

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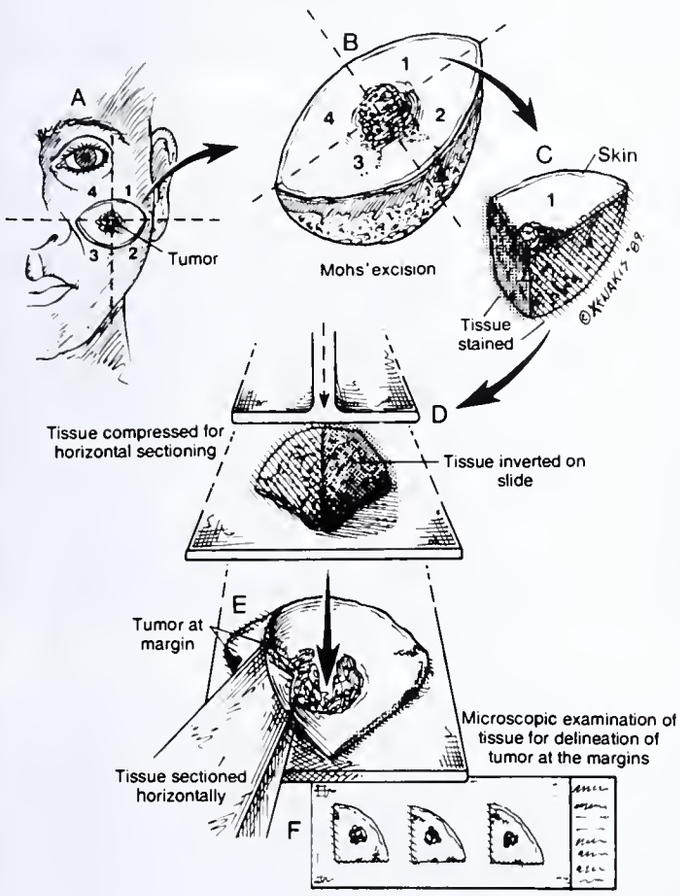

Fig. 1. Initial Mohs surgical excision. Note beveled sides of excision (B) and horizontal sectioning (E).

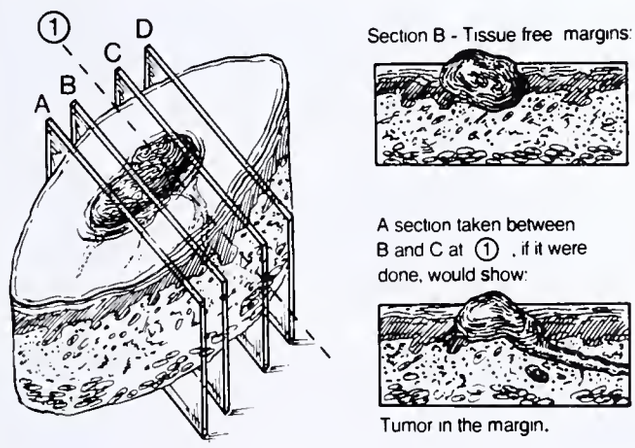

Fig 2. Left, gross conventional excision with random vertical sections. Right, microscopic exam.

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Although it is impossible to know the exact incidence of skin cancer in the United States, it is recognized as being our most common malignancy. The general incidence, probably underestimated, is often quoted as 500,000-600,000 new cases per year.[1] Of these, basal cell carcinoma (BCC) is much more frequently encountered. The ratio of BCC to squamous cell carcinoma (SCC) varies, depending upon the type of practice and geographic latitude of the reporting authors, but usually is thought of as being 6:1 to 10:1. Fortunately, malignant melanoma (MM) is the least common of the three commonly seen skin cancers, and accounts for an estimated 27,000 new cases per year.[2]

The incidence of non-melanoma skin cancer is felt to be rising, as is the incidence of melanoma. From the 1960s to the 1980s the incidence of SCC has increased almost three times, and that of melanoma four times.[3]

There are a number of well-recognized and accepted methods used in the treatment of skin cancer. The most commonly employed therapeutic modalities include curettage and electrodesiccation (not for melanomas); excisional surgery; radiation therapy (not as primary therapy for MM); and cryosurgery. Each of these methods requires appropriate patient selection.[4]

Cure rates for primary non-melanoma skin cancer using these modalities varies from 77% to 98%, depending upon the method chosen, tumor type and location, and reporter's special interest and inherent bias.[5-7] It is well recognized that the cure rate for recurrent tumors is significantly lower and may only approach 60%.[8] It is also appreciated by those who treat skin cancer on a regular basis that certain histopathologic subsets of tumor types (such as morphea-like basal cell carcinoma, sclerosing basal cell carcinoma, and basosquamous carcinoma) and those tumors in certain anatomic locations (inner canthus, nasolabial, and periauricular sulcus) predispose to higher recurrence rates. Certain subsets of the patient population (younger patients and in particular, young women) may also be at increased risk for tumor recurrence.[5,9]

Mohs surgery, also known as Mohs micrographic surgery or microscopically controlled surgery, is a very precise method of excising skin cancer (Fig. 1), affording cure rates of 99% in primary basal cell carcinomas and 95-96% in the more difficult or recurring lesions.[10] This method is not new. It was developed by Dr. Frederic Mohs at the University of Wisconsin about 45 years ago. The technique (Table 1) is time consuming, labor-intensive, and is performed by only a relatively few physicians because of the requirements for special facilities, personnel, and training. These requirements may necessitate an increased cost for tumor removal when compared to simple excision. However, for many tumors, this increased cost is offset by the high cure rate (negating the need for subsequent treatments) and preservation

Table 1. Steps Involved in Mohs Micrographic Surgery.

1. Locally anesthetized tumorous area thoroughly curetted to debulk and help delineate margins.
2. Reference map drawn corresponding exactly to patient's lesion and showing important adjacent anatomic landmarks.
3. Grid-like identification marks drawn over area to be excised and drawn in on reference map.
4. **Saucer-like** excision performed.
5. Excision divided into appropriate-sized sections, each assigned a number, and sections replicated on map.
6. Contiguous edges dyed in different colors and indicated on map.
7. **Tangential frozen** sections performed on each section in Mohs surgery laboratory to encompass undersurface of specimen and entire peripheral (epidermal) margin.
8. Sections stained and examined microscopically by the Mohs surgeon.
9. Location of any residual tumor plotted on map.
10. With map adjacent to patient's surgical wound, exact location of residual tumor can be determined. If tumor is still present, another thin layer, encompassing the "tumor-positive" area, is excised and processed as above. This procedure is repeated as many times as necessary until tumor-free margins are achieved.

of normal tissue and function.[11,12] Compared to excision in an operating room with "frozen section control," Mohs surgery is extremely cost effective. Mohs micrographic surgery units currently exist at, or in affiliation with, the three Virginia medical schools.

Micrographic vs Excisional Surgery

Conventional excisional surgery is performed with scalpel blade cutting perpendicular to the skin's surface. Regardless of the geometric design of the excision, the removed specimen has vertical sides, or edges. It is impossible to examine the tissue margins microscopically in their entirety unless one cuts vertical sections around each edge and cuts a horizontal section across the entire specimen base. The most common method of "checking margins" is based upon some form of "bread-loafing" (Fig. 2). Using this method, a number of vertical slices (generally 3-5) are taken from the specimen and examined histologically. What about the intervening tissue that is not removed for examination? In a specimen 1.0 centimeters in length, there would be, depending upon the thickness of the slice removed for microscopic examination, 2000 slices (if they were 5 microns in thickness). An analogy to this would be to take a book and stand it on its binding. One can readily appreciate the lack of information that would be obtained by removing only 4 or 5 of the pages for examination. If one were to take several slices, or pages, from the ends and the center, it would enhance our knowledge of the contents but still leave a lot to be desired. What about all the other slices. Do they contain tumor, and does it extend to the margins?

Fortunately, most primary skin neoplasms are solid in nature (like a pea or bean in the skin) and representative sections prove to be adequate in a large percentage of cases. However, some types of tumors have tentacle-like strands of tumor cells extending beneath the surface in a subclinical manner. These tumors are often recurrent tumors and morphea-like basal cell carcinoma. This same growth pattern is also frequently seen in scars and in certain anatomic locations, especially in embryonic fusion planes such as the inner canthus, the nasolabial and periauricular sulci, and where the overlying skin is bound down to an underlying structure, such as the cartilage of the ear or the ala nasi. Unfortunately, in these situations conventional "margin checks," whether by frozen section or paraffin-embedded sectioning, frequently prove to be inadequate.

Indications for Mohs Surgery

In this author's experience the major indications for Mohs micrographic surgery are as follows:

1. Recurrent tumors, for reasons already cited in the text. The cure rate by other methods is less than satisfactory.

2. Certain anatomic locations have already been alluded to and include nasolabial sulcus, inner canthus (Fig. 6), periauricular sulcus, ala nasi, concha of ear. These areas have higher than "normal" recurrence rates.

3. Tumors with poorly defined margins (Fig. 3) could best be treated with Mohs surgery. If the margins are not well-defined grossly, it adds to the chance of inadequate treatment.

4. Certain histopathologic types: morphea-like (sclerosing) BCC and basosquamous carcinoma. The sclerosing BCC is notorious for resisting initial treatment attempts as it is poorly defined and beneath the surface has subclinical extension with pseudopodic strands of tumor cells. Basosquamous carcinoma is invariably more invasive than its appearance indicates.

5. Large or aggressive tumors (Fig. 5). These may be primary or recurrent in nature. It should be noted that Mohs surgery results in the smallest adequate excision while simultaneously offering the highest cure rate. This maximal conservation of normal tissue allows it to be well suited for lesions in important anatomic areas where one wishes to minimize the extent of surgery and subsequent scar. This is of particular value in younger persons who may be at increased risk of recurrence (see Cases 1 and 2).

Tissue conservation is also important for cancers on the penis or digits (Fig. 4), where the only alternative may be amputation.

Case Reports

Case 1. A 39-year-old woman was referred for a poorly defined basal cell carcinoma overlying the left lateral eyebrow. She was born and raised on a farm in the South and had had one previous skin cancer.

Fig. 3 (upper left). Poorly defined and recurrent basal cell carcinoma of nasal tip.
Fig. 4 (upper right). Squamous cell carcinoma of right index finger.
Fig. 5 (lower left). Recurring squamous cell carcinoma of postauricular region.
Fig. 6 (lower right). Sclerosing basal cell carcinoma of medial canthus.

Fig. 7, Case 1. Upper left, preoperative view of 39-year-old woman with poorly defined basal cell carcinoma of left suprabrow. Upper right, postop defect after four conservative excisions. Lower left, side-to-side closure. Lower right, followup at 10 weeks.

Fig. 8, Case 2. 25-year-old man with squamous cell carcinoma of lower lip.
Top, preoperative appearance of granulomatous lip lesion.
Middle, postoperative appearance after three surgical excisions using Mohs micrographic surgery.
Bottom, appearance at four months with minimal distortion after healing by second intent.

Clinically, the lesion was poorly defined and measured approximately 1.5 × 2.0 cm (Fig. 7A). Initial excision, after curettage, revealed tumor extension in medial and inferior margins. The "positive" areas were sequentially excised (total of four excisions) until a tumor-free defect was achieved, measuring 2.0 × 2.5 cm (Fig. 7B). The defect was closed primarily in a side-to-side manner (Fig. 7C), and early (10-week) postoperative results were acceptable to both the patient and myself (Fig. 7D).

Case 2. A 25-year-old man presented himself with a nonhealing lesion of the lower lip of three months duration. His skin was of a Type I. With the exception of cigarette smoking, no etiologic possibilities were noted. Examination revealed a 1.5 × 1.0 cm granulomatous, indurated lesion of the left lower lip (Fig. 8A). No regional adenopathy was palpable. A wedge biopsy confirmed this to be a squamous cell carcinoma. The patient underwent Mohs micrographic surgery in three stages (three excisions) before a tumor-free plane was achieved. The subsequent defect measured 3.0 × 1.5 cm (Fig. 8B) and was allowed to heal by secondary intention, using daily wound care. Healing was uneventful over a four-week period, leaving minimal deformity at four-month followup (Fig. 8C). He has been followed closely for one year with no evidence of local recurrence or regional metastasis. The nature of his disease warrants close followup for the first five years, then periodically (1-2 times per year) indefinitely. He was advised to cease cigarette smoking, which he did.

Conclusion

Mohs micrographic surgery is a highly effective method of surgically removing neoplasms with complete microscopic examination of the removed tissue. The result is maximum preservation of normal tissue and high cure rates even for difficult-to-cure skin cancers. It is generally performed under local anesthesia as an outpatient procedure. Extremely difficult cases because of extent or location may require a team approach.[13] Rarely, extensive cases may require inpatient management due either to extensive tumor involvement or medical frailty of patient.

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New for Gallstones: Video Laparoscopy for Cholecystectomy

Stephen B. Edge, MD,
B.D. Schirmer, MD, and Janet Dix, PA,
Charlottesville, Virginia

GALLSTONE disease is a serious public health problem, accounting for over 750,000 hospital admissions and 450,000 operations per year in the United States. Until recently, cholecystectomy by laparotomy was the only treatment available for symptomatic cholelithiasis. While fully effective and safe, open cholecystectomy (OC) entails significant pain and discomfort with disability lasting 4-6 weeks. Alternative therapies for cholelithiasis include extracorporeal shock wave lithotripsy (ESWL), dissolution therapy with oral ursodeoxycholic acid or methyl tert-butyl ether gallbladder irrigation.[1,2] These therapies are markedly less effective in treating gallstones than OC and experience to date suggests they will not have the broad application initially hoped.[1-4]

A new technique, laparoscopic cholecystectomy (LC), allows cholecystectomy without laparotomy. LC was first performed in France in 1987 and in the U.S. in 1988-89.[5,6] To date, an estimated 2000 patients have had LC in the U.S. Advantages of LC over OC include diminished postoperative pain and disability. Most patients are discharged within 24 hours of LC and return to full activity and employment within one week. Thus LC retains the full efficacy of cholecystectomy without the drawbacks of pain and economic loss to the patient.

This paper reports the initial experience of the LC program at the University of Virginia. We also make suggestions and offer guidelines for other institutions planning LC programs.

Materials and Methods

Training: SBE and BDS received LC training at Mount Sinai Medical Center in Chicago, Illinois. The three-day course, sanctioned by the Society of American Gastrointestinal Endoscopy Surgeons (SAGES), included didactic sessions and extensive animal laboratory experience (porcine model). Further animal experience was obtained at the University of Virginia to familiarize OR staff. The first ten procedures were performed with both BDS and SBE in attendance.

Technique: General anesthetic with endotracheal intubation are used with bladder and stomach drainage. With a CO_2 pneumoperitoneum, a 10-mm trochar is placed below the umbilicus into the abdomen. After inspection for other pathology and adverse conditions, a second 10-mm trochar is placed at the xiphoid, and accessory 5-mm trochars placed just above the anterior superior iliac spine and below the costal margin (Figure 1). The gallbladder (GB) fundus is retracted superiorly to expose the porta hepatis and fixed in place. The neck of the GB is retracted laterally through the subcostal trochar. Using insulated scissors, hook and spatula LC instruments with cautery through xiphoid trochar, the cystic duct and artery are dissected free. A clip (Endoclip, Autosuture, Inc.) is applied to the cystic duct flush with the GB. Cholangiogram is performed through a 6F whistle tip uretral catheter placed in the cystic duct. The catheter is removed, the proximal cystic duct clipped and divided, and the cystic artery clipped and divided. The GB is dissected off the gallbladder bed with electrocautery. The GB is drawn into the infra-umbilical trochar and brought through the abdominal wall. The skin is closed and the wounds injected with bupivicaine (Marcaine®).

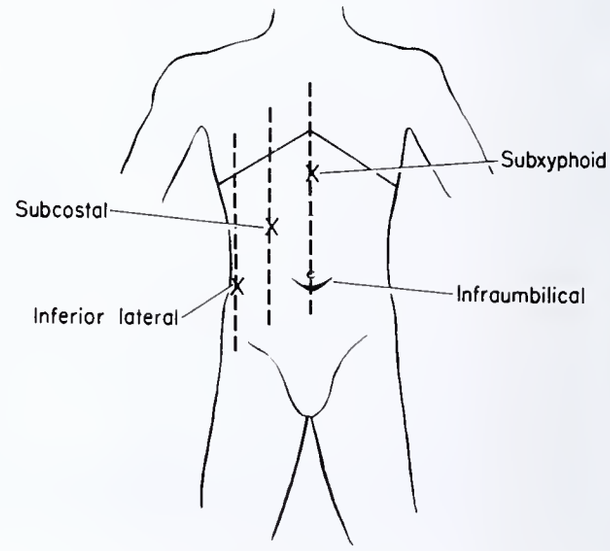

Figure 1. Laparoscopic trochar placement for cholecystectomy. Telescope through infraumbilical trochar, working instruments through other three trochars. Fifth trochar occasionally used to aid duodenal retraction.

Patients: From February 23 to April 16, 1990, 20 patients underwent laparoscopy for cholecystectomy at the University of Virginia. All had symptoms of gallstone disease and proven cholelithiasis by ultrasound. Consent was obtained under an investigational permit approved by the Human Investigation Committee of the UVa Health Sciences Center.

Results

We attempted LC on 20 patients. Age ranged from

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Submitted 6-18-90.

23-84 years with 16 females. Weight ranged from 50-100 kg. Four had a single large stone, Three had two stones and 13 had three or more stones.

LC was successful in 18/20. Cholangiography was attempted in 14 and successful in nine. No common duct stones were found. Two anatomic anomalies identified included a short cystic duct and an accessory right hepatic artery. Two patients (10%) were converted to open cholecystectomy at surgery, one for a retractor tear in the gallbladder which could not be controlled and the other because the cystic duct was too short for clip closure. Both recovered without complication. Nineteen of 20 patients were admitted the day of surgery. Of those who completed LC, 16/18 were discharged the day after surgery eating a regular diet. Nausea was common the day of LC but resolved by morning. Analgesia use was minimal with most only taking oral medication. Five out of 18 required no parenteral narcotics after leaving the recovery room. All LC patients returned to normal activity within one week of the procedure.

Two patients had intraoperative complications. One patient developed extensive subcutaneous emphysema near completion of LC with pCO_2 of 95 and pH 7.06. LC was completed with rapid resolution of blood gas abnormalities and subcutaneous emphysema. The second complication was a gallbladder tear during extraction in our second patient, spilling stones onto the omentum. The debris was removed piecemeal and the patient recovered without incident.

Discussion

Laparoscopic cholecystectomy is a new procedure with marked benefits over other treatments for symptomatic cholelithiasis. While retaining the complete efficacy of OC, LC reduces hospital stay, perioperative pain and disability and overall cost. It is likely to replace 60-80% of open procedures.

LC appears safe, but must measure up to the proven safety of OC.[7] Bile duct and arterial injuries are grave complications of cholecystectomy which might occur more frequently with LC if anatomic anomalies go unrecognized. Our early experience and that of others indicates that the LC dissection is safe.

The reduction in perioperative discomfort and disability with LC make cholecystectomy a more palatable option. This may further limit the use of ESWL and dissolution therapy. ESWL is most effective for single stones <20 mm. In the Dornier study, 50% were stone-free one year after treatment (combined with ursodeoxycholic acid).[3] With two or three stones, success is less likely (22% stone-free at 6 months). Patients with >3 stones have not been treated. Patients treated with ESWL are at risk for stone recurrence. Oral dissolution therapy is effective in about 30% of patients, requires up to two years of treatment, and costs $4 per day.[2,4] It is most effective in those with very small single stones. Stones recur in at least 50% of patients within 2-5 years, requiring retreatment or cholecystectomy.

The indication for LC is symptomatic cholelithiasis. The reduced discomfort of LC should not extend the indications for cholecystectomy to include asymptomatic gallstones. There are no absolute contraindications to LC except anesthetic risk and bleeding disorders. Relative contraindications include extensive previous upper abdominal surgery, a scarred, contracted gallbladder obscuring anatomic detail, and acute cholecystitis. However, LC has been performed in all these settings. An initial attempt at LC with conversion to OC if needed is now our standard practice. All patients must be informed with signed consent of the possibility of intraoperative conversion to OC.[6] In our initial 20 patients, two (10%) were converted to OC.

We use monopolar electrocautery for hemostasis and dissection. Other groups use bipolar cautery or laser (KTP or contact Nd:YAG). There is no advantage of any dissection technique over another. Electrocautery is readily available and easy to use. Laser adds significantly to both the startup and ongoing cost of the procedure without added benefit.

LC is gaining rapid acceptance in the surgical community. At the time of this writing, four centers in Virginia have performed LC. The procedure requires special training and equipment. Training in laparoscopic surgery is now an integral part of our residency training program. For surgeons already in practice, significant time and effort is needed to secure adequate training. Courses offered for practicing surgeons vary in "hands on" experience from a single procedure in the guinea pig to numerous procedures in 30-40 kg pigs. Requirements for course sanctioning by SAGES include participation in six porcine LC procedures (two each as camera operator, 1st assistant and surgeon).[8] The course offered at the University of Virginia includes participation in nine porcine procedures.

Institutions need to define training and credentialing criteria for practicing surgeons to ensure safe introduction of the procedure. Reasonable credentialing guidelines include 1) full training and privileges in biliary tract surgery; 2) completion of an LC course with sufficient animal experience as outlined above; 3) demonstration of diagnostic laparoscopy skills; 4) preceptorship for 3-5 cases by a surgeon experienced in LC; and 5) LC to be performed by two surgeons with knowledge of the procedure (senior resident or second staff).

The widespread use of laparoscopy in general surgery will surely herald the development of other applications of minimal access surgery as it has in gynecology. Laparoscopic appendectomy is possible in many cases and at least one investigator has performed laparoscopic parietal cell vagotomy.[9] A clip for internal inguinal ring obliteration is under development for laparoscopic herniorrhaphy.[10]

POINT OF VIEW

Compulsory Medical Education: The Downside

TO ENTER the profession of medicine is to embark upon a lifetime commitment to education. In that sense, continuing medical education (CME) is simply an expression of that commitment. In 22 states, continuing medical education credits are now required for licensure (Virginia is not among them); many medical societies require CME credits for membership (including the Medical Society of Virginia); and most specialty boards require CME credits for recertification.

We are beginning to see the undesirable side effects of mandatory continuing medical education. By this time we all passively accept the increased record keeping, the outrageously high cost of acquiring the appropriate credits, the hypocrisy involved in taking a cruise or vacationing on a tropical isle while taking a course for CME credit. I personally have lost the embarrassment of asking whether I will be getting CME credit for a course, lecture, or seminar, rather than just wondering whether it will be interesting or beneficial to me. It seems the dim past, although it is only a few years ago, when we physicians could choose on our own what was necessary to further our education.

Compulsory CME is simply not the best way to further a physician's growth in knowledge and ability. It uses only the negative connotation of punishment, rather than any true positive reward. Yet we have seen a whole new industry developed for providing, documenting, and judging of CME, all this at a high cost to be paid for in state and national society dues, in the cost of the meetings, and in the extra work and documentation in our offices. Of course this expense is passed on to our patients. Although there is evidence that knowledge is gained from CME (this of course has always been true), there is no evidence that it significantly alters practice. Without ever more complex and onerous controls, how does one deal with someone who arrives late at a meeting or leaves early, who daydreams through the program, or who takes a brief catnap, particularly in postprandial or evening meetings? How do we prove that what was presented was learned? How do we prove that what was learned was applied? How do we prove that what was applied alters outcome? I am not arguing against altered (improved) outcomes, nor the fact that increased knowledge is a factor (but not the only factor) in improved outcomes—only the means of proving it via forced education.

There is an implied assumption, based on the methods of our schooldays, that most learning comes from a formal setting wherein a teacher passes on knowledge to a student who supplements the classroom knowledge with "homework." Although I am sure that this continues to hold true to some extent throughout the clinical years, I doubt that this makes up the bulk of applied knowledge. Methods of learning are highly individualized. Some learn best in solitude, others in a crowd. Some need background noise (music or voices), some need complete quiet. Some learn best by visual means (watching a tape, reading a book, or direct observation), some by oral means (discussions, seminars), some by aural means (lectures, cassette tapes), and most by a combination of these. It is my strong suspicion that far more applied clinical knowledge is learned in hospital corridors and nursing stations, doctors' lounges, and hospital cafeterias and in telephone discussions of patient problems than by any formal CME program. (This is probably not true of basic knowledge, which must be transmitted in a more formal setting.)

ONE VIEW expressed early on was that if we did not do something about policing our profession, the government would. Well, we have done something, and Congress, in the person of Rep. Fortney "Pete" Stark, has responded in a predictable fashion. He has introduced HR 4464, which, if passed (not likely for now but a portent for the future), would mandate that physicians would have to take a profi-

ciency examination if they are to be permitted to treat Medicare patients (Am Med News, 4 May 1990). So much for the theory that lawmakers could be held off if we embarked on self-policing.

Our professional organizations ought to insist that if repeated testing is the measure of proficiency, then Congress ought to lead the way. Not only members of Congress but their legislative assistants ought to be required to be examined periodically on U. S. history, the U. S. Constitution, and constitutional law, political science, economics, and, most importantly, ethics. Those who fail the testing should be forced to give up their positions and leave Washington so they cannot end up with lucrative "consulting" positions, all too often a euphemism for influence peddling.

There is another proposal I would make. On the 10th anniversary of graduation from medical school and every ten years thereafter, I propose a compulsory return to school of approximately three weeks. Although beneficial from an educational standpoint (for example, the first week could be devoted to basic science, the second to general clinical medical advances, and the third to advances in one's own and related specialties), the basic purpose would be renewal for the physician. This would be both physical and mental renewal. Activities outside the formal classroom environment would include basic health parameters performed on each physician, with followups to see that corrections are taken; organized discussions of subjects ranging from medical ethics to impaired physicians to practice problems to health policy matters; and of course renewing old acquaintances in a relaxed and informal environment. This could give each physician the psychic energy to face the coming decade.

David A. Zohn, MD

Dr. Zohn, who specializes in physical medicine/rehabilitation, is in private practice at 1515 Chain Bridge Road, #102, McLean VA 22101.

Summary

Laparoscopic cholecystectomy is a new technique for treatment of symptomatic cholelithiasis. Advantages of efficacy, reduced pain and shortened disability make this the preferred treatment. The procedure can be learned by surgeons versed in biliary surgery. Physicians not fully trained in biliary tract surgery should not perform LC because of the dangers of bile duct and arterial injuries, and because of the need for immediate open surgery in 5-10% of patients.

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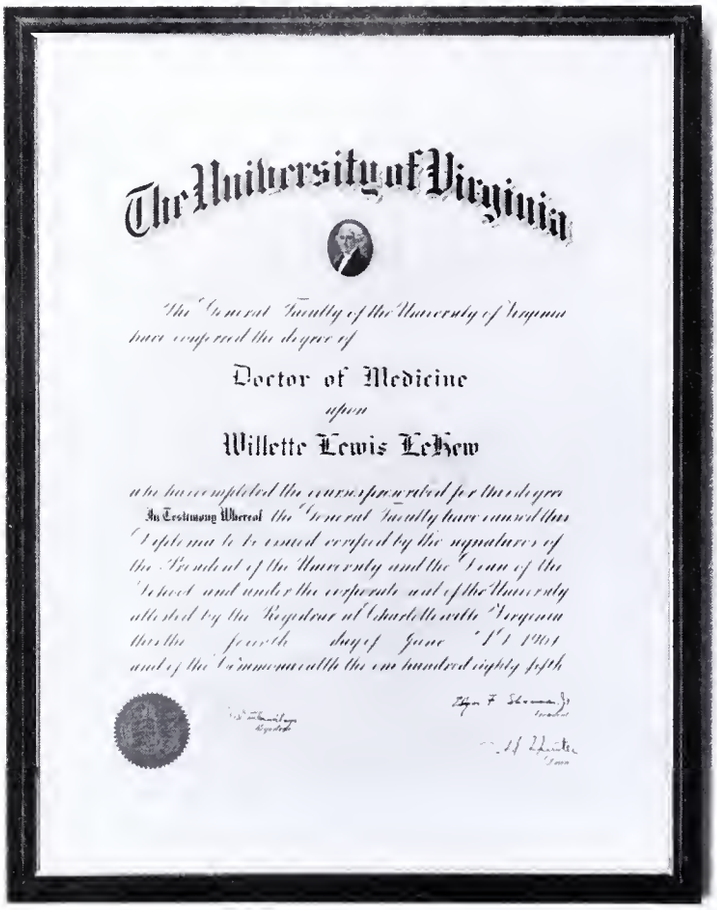

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upon

Willette Lewis LeHew

who have completed the courses prescribed for this degree

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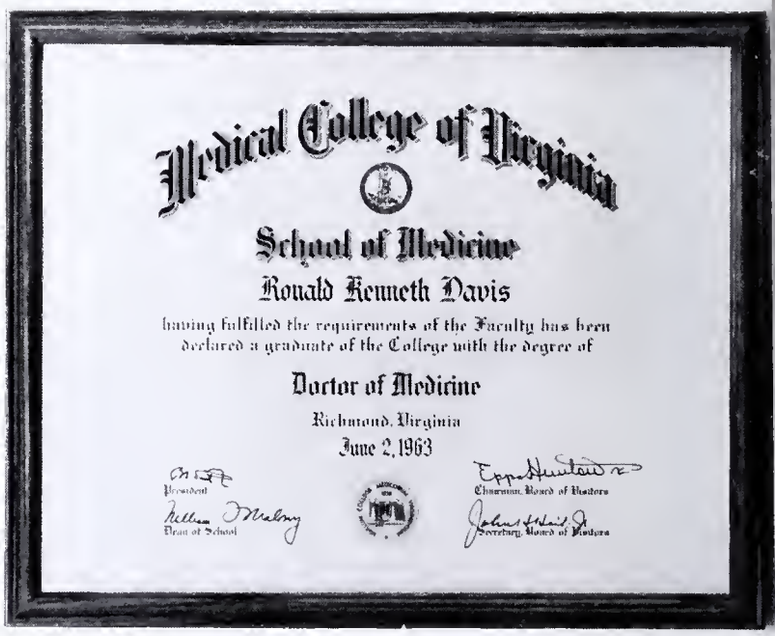

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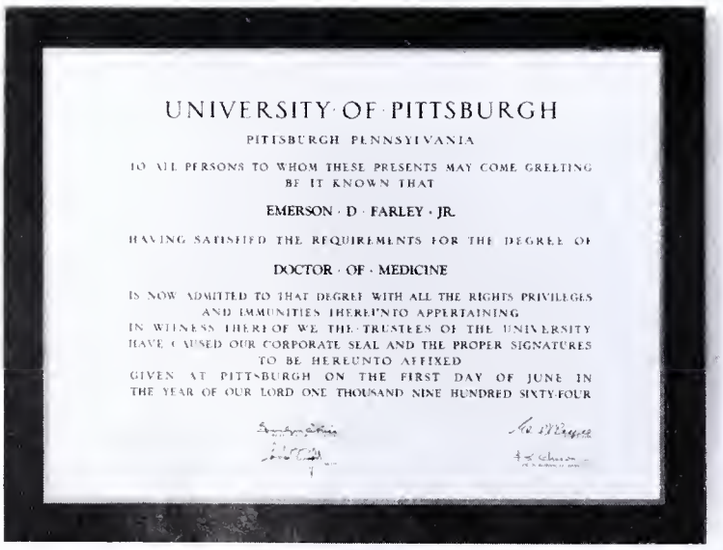

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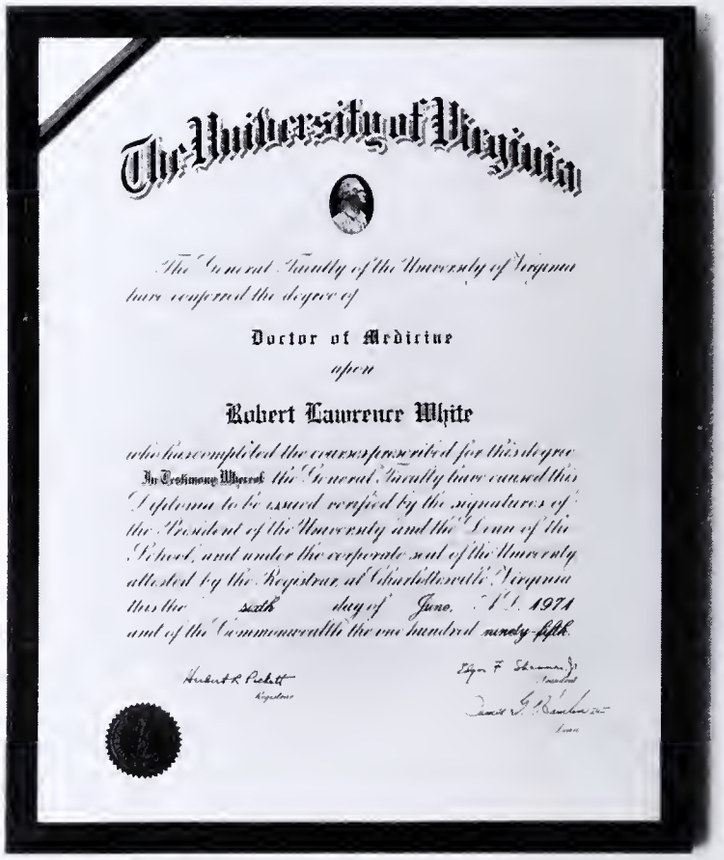

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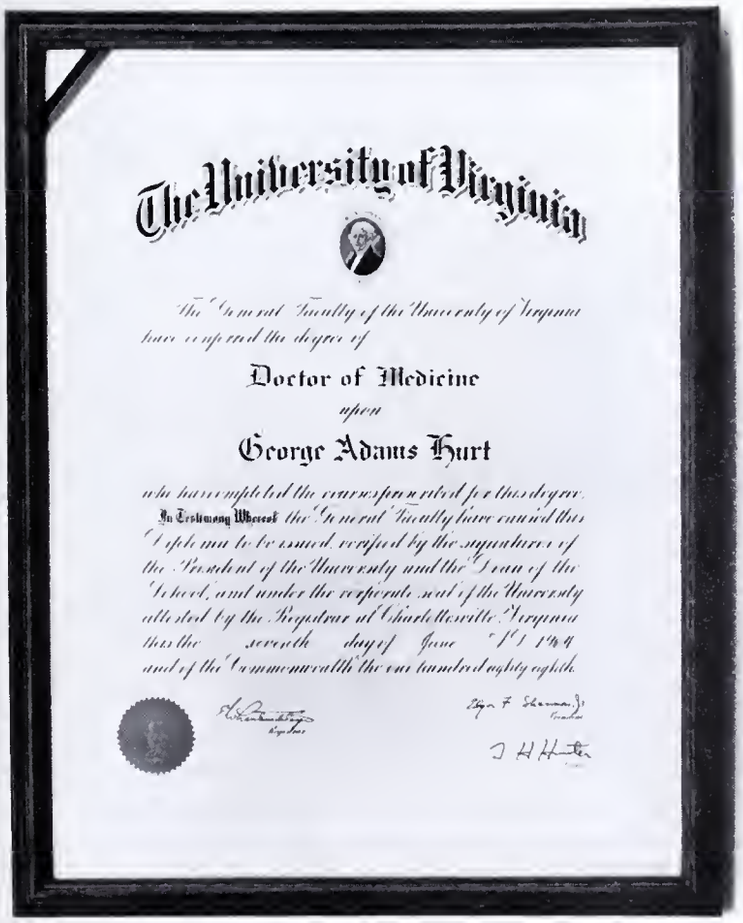

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Avoidable Claims in the Liability Experience of Virginia FPs Insured By the Reciprocal

Jen Lee Nelson, MHA, and
Barbara S. Brown, PhD,
Richmond, Virginia

A STUDY of the Virginia Insurance Reciprocal (TVIR) liability claims experience for family physicians was conducted to summarize the frequency and severity of claims. Claims adjudicated between 1981 and 1989 were reviewed to provide an understanding of physician and claimant characteristics, areas of greatest risk and loss, and allegations made. Another goal was to identify factors that could prevent malpractice claims against family physicians. The analysis illustrates the impact risk management strategies can have in reducing malpractice losses.

Materials and Methods

Claims filed from January 1, 1981, through December 31, 1989, were reviewed. During the nine years, 120 claims were filed against family physicians insured by the Reciprocal. Of these 120 claims, 79 (66%) were closed as of December 31, 1989, and 41 (34%) were still open on that date. The files for all identified closed claims were analyzed.

All claims were made against Virginia physicians. The Reciprocal insures an estimated 37% of the family physicians in Virginia, of which approximately 15% were involved in a claim during the study period.

The files of 73 of the 79 closed claims were available and were abstracted to identify information on the frequency and cost of claims. Claims with and without payments were included. Each claim represented one occurrence. For each occurrence, more than one physician could have been sued; however, the claim was treated as one case. In addition a physician may have been sued for more than one incident within the study period.

Information collected included: claimant's age, sex, occupational status at time of alleged injury; physician's type of practice (solo or group), board certification, number of years in practice at time of alleged injury; location where alleged negligence occurred.

The allegations of negligence made in each claim were grouped into seven categories. Risk management issues were identified from information recorded in the claims reports and other summary information in the files. A cost analysis was done for all closed claims. Claims payments and litigation costs associated with each claim were noted. Dollar figures were adjusted using the U. S. City Average Medical Care Price Index as the conversion factor.

A summary analysis was done to determine which claims might have been avoided if certain risk management strategies had been implemented.

Results

The Claims

The 73 claims involved 66 family physicians, which is approximately 15% of the family physicians insured by the Reciprocal and an estimated 5% of the total family physicians practicing in Virginia in 1989. The analysis showed that 41% of the closed claims involved an insured physician and at least one other health care provider, and 44% of the claims were against individual insured physicians only. The remaining 15% represented the closed claims involving a family physician insured by TVIR and a provider insured by another liability carrier.

As of December 31, 1989, 36 claims (49.3%) had been closed with indemnity payments made on behalf of the physician and 37 claims (50.7%) were closed with no payment. This is consistent with national trends. [1] Table 1 shows the number of paid claims and total indemnity payments by payment ranges.

Table 1. Payment Ranges of 36 Paid Claims Against Family Physicians Insured by the Virginia Insurance Reciprocal 1981-89.

Payment Ranges	Number of Paid Claims	Total Actual Indemnity Payment
$1 to $999	1	$ 151
$1,000 to $4,999	5	11,935
$5,000 to $9,999	6	46,500
$10,000 to $24,999	8	120,699
$25,000 to $49,999	2	57,500
$50,000 to $99,999	4	272,500
$100,000 to $249,999	7	1,000,000
$250,000 to $499,999	0	0
$500,000 and Greater	3	2,087,060
Total	36	$3,596,345

Year of payment, frequency and total adjusted payment (inflation factor applied) for all closed claims are shown in Table 2.

The length of time elapsing between the alleged injury to the filing of a claim ranged from less than one month to 48 months (four years). The time period most frequently noted was 19-24 months. Five percent of the claims were filed within the same month the alleged injury occurred, and about 8% of the claims took two years or longer to be filed.

The length of time from filing of the claim to

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complete disposition ranged from greater than one month to 76 months (6.3 years). The majority (79%) of the claims made against family physicians were resolved within two years of filing.

The principal allegations of negligence were identified and are shown by category in Figure 1. As Table 3 shows, medication- and treatment-related allegations had the highest total payout of all allegation categories. The single obstetric-related claim accounted for $827,108, or 18% of the total payout for family physicians during the study period.

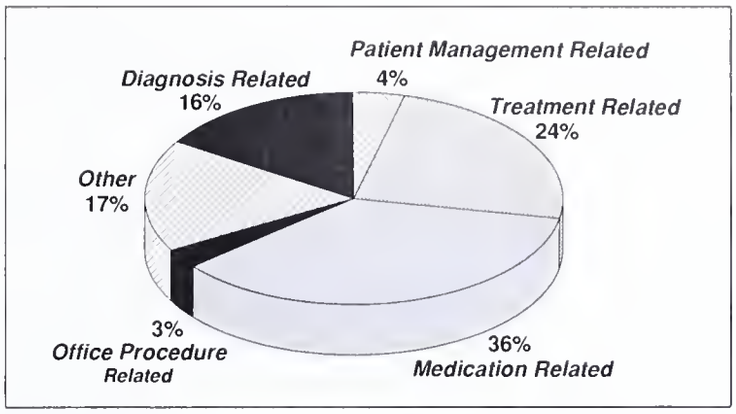

Fig. 1. Percent of Total Payment by Allegation Category of Closed Claims Against VIR-Insured Family Physicians in 1989.

The Physicians

Of the 66 family physicians involved in claims during the study period, 60 had a single claim made against them, five had two claims, and one physician had three claims within the 9-year period. The fact that the majority (91%) of the physicians had only one claim against them suggests that claims activity does not identify, or is not necessarily linked to, poor medical practice.[2-4]

Of the 73 closed claims studied, 64% involved physicians who were board certified in family practice. This same board certified group accounted for 63.7% of the total payments for these claims.

About 47% of the family physicians were in individual (solo) practice, and the remaining 53% were distributed over groups of varying sizes. The majority of the claims (81%) were concentrated in solo practices and groups of two and three physicians.

Analysis of the number of years that physicians involved in these claims had been in practice at the time of the alleged injury revealed that the largest percentage of claims (60%) represented physicians in the first 15 years of practice. The other 40% of the claims were spread over longer practice ranges.

The family physician's office was the setting for 49% of the alleged injuries, and these claims accounted for $3,402,867 (73%) of the total payout for this specialty. The remaining 51% of the alleged injuries occurred in the hospitals, nursing homes, health departments or prison clinics.

The Claimants

When analyzed for claimant's age, the 73 closed claims appeared to be evenly distributed, with a slight increase in claims in the 40 years and older range. The age range most often represented was 65 years and older (14 claims made). Only 5% of the claims were on behalf of patients injured at birth to 1 year old.

About 53% of the claims were made by females, and 47% by males. Female claimants accounted for $2,428,781 (52%) of total payments made, males for $2,205,595 (48%).

Over one-third (37%) of the claimants were employed (self-employed included) at the time of alleged injury, and 27% were either homemakers, dependents, or unemployed. Incarcerated individuals in the state

Table 2. Year, Frequency and Adjustment Payments in 36 Claims Against Family Physicians Insured by the Virginia Insurance Reciprocal 1981-1989.

Payment Year	No. Claims Closed	Actual Indemnity Payment ($)[1]	Actual Expenses Payment ($)[1]	Total ($)[1]	Avg. Payment per Claim ($)[1]
1984	4	18,931	12,541	31,472	7,868
1985	7	98,764	62,299	161,063	23,009
1986	13	1,446,533	118,122	1,564,655	120,358
1987	12	1,750,904	177,084	1,927,988	160,666
1988	18	563,523	55,918	619,441	34,413
1989	19	275,000	54,757	329,757	17,356
	73	4,153,655	480,721	4,634,376	491,973

Table 3. Payment by Allegation Category in 36 Claims Against Family Physicians 1981-89.

Allegation Category	Number Claims	Percent Of Total Claims	Total Adjusted Payment	Percent of Total Adjusted Payment
Diagnosis-Related	23	32	738,171	15.9
Treatment-Related	20	28	1,101,487	23.9
Office Procedures-Related	12	16	127,444	2.7
Medication-Related	11	15	1,669,098	36.0
Patient Management-Related	5	7	171,068	3.7
Biomedical Equipment-Related	1	1	0	0
Obstetrics-Related	1	1	827,108	17.8
Total	73	100	4,634,376	

[1]Dollar amounts adjusted to reflect 1989 dollars

correctional system accounted for 7% of the claims.

Table 4 shows the number of avoidable claims and the total dollar amounts represented by each in five risk management categories.

Discussion

Over the past nine years, the claims experience of family physicians insured by the Virginia Insurance Reciprocal indicates that about half of all claims made were closed with no payment. Loss payments showed high variability, with an average payment of about $8,000 per insured family physician. It took an average of 13.5 months from the time of alleged injury to file a claim, and an average of 16.3 months from the date of filing to fully resolve a claim. Allegations of diagnosis- and treatment-related errors were made most frequently, and those related to medications were the most costly in terms of paid losses.

The data suggest that board certification is not linked to the incidence of malpractice claims. This is likely due to the fact that most of these insured physicians were board certified, making it a weak indicator of medical expertise.

Physicians practicing in groups of four or more had a lower incidence of claims than those in solo practice. Larger groups are more likely to implement systems to monitor, flag, and followup patient care. In addition, the peer review available in group practices may influence the quality of diagnosis, treatment, and medication regimens. [5,6]

Physicians in their first 15 years of practice were named more often in the studied claims than those who had practiced longer. Although the data cannot provide conclusive evidence as to why this trend occurred, it can be proposed that the stability of the practice and established relationships with patients influenced this finding. The most common reason for initiating a suit is patient dissatisfaction. The dissatisfaction can stem from poor bedside manner or the patient's perception that the physician was not thorough or did not render adequate care. [2,3] The cure for dissatisfaction is communication with the patient and thorough and legible documentation of the patient visit. [2,4,7]

Approximately one-half of the closed claims in this sample occurred in the family physician's office. Such losses should be easier to avert than those originating in a hospital or other health care setting in which the physician has less influence on procedures.

Thirty-six (49.3%) of the 73 claims could have been prevented by implementing effective risk management practices. These claims resulted in a total loss of $2,878,678 (62.1%) of the total cost of all the claims.

Summary

In response to the threat of litigation, physicians practice defensive medicine. A more effective means of reducing malpractice liability and improving the quality of patient care is to practice defensible medicine, i.e., those practice patterns that reduce the potential for claims and increase the likelihood that when claims do arise, they can be successfully defended. [3]

Unlike hospital-based specialists, family physicians can directly influence a significant portion of their risk of suit. By focusing management time and attention on the factors in their office practices that are linked to malpractice claims activity, family physicians can reduce the likelihood of being involved in claims.

Table 4. Avoidable Claims in 36 Paid Claims Against Family Physicians 1981-89

Risk Management	Number of Claims	Total Dollar Amount[1]
Scope of practice and training of office personnel	10	$ 429,163
Documentation practices and patient communication	6	258,766
Systems to monitor, flag and followup patient care	8	1,343,896
Coordination of care among health care team	7	112,139
Office procedures	5	734,714
	36	2,878,678

[1]Dollar amounts adjusted to reflect 1989 dollars

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SAFEGUARDS AGAINST SUIT

Physicians are responsible for ensuring that all employees and allied health personnel are properly trained and credentialed. Problems that lead to litigation occur when the office receptionist or medical assistant gives medical advice over the phone without the knowledge of the physician. Other suits have arisen from injections being given by untrained and unsupervised assistants. Periodic retraining of employees is as important as initial training. Office personnel need continuing education as much as the physician to keep abreast of new issues and maintain and hone skills.

Documentation practices influence the ability to defend a claim. Charts with pencilled notes, correction fluid alterations, no dates or initials on changes, or lost or missing record components give the impression of poor quality care or altered evidence. The medical evidence is put on the stand as much as the physician. From the point of view of the plaintiff's attorney, if it isn't recorded it didn't happen. A system of physician review prior to filing the patient's record is essential to insure completeness and to document patient compliance with recommendations.

Patient communication is the root of most medical malpractice claims. Patients' perceptions are important. The physician and staff have ample opportunity to shape these perceptions. The time spent with the patient, the rapport built during that time, and the feeling of physician accessibility are perhaps the greatest insurance against a liability claim.

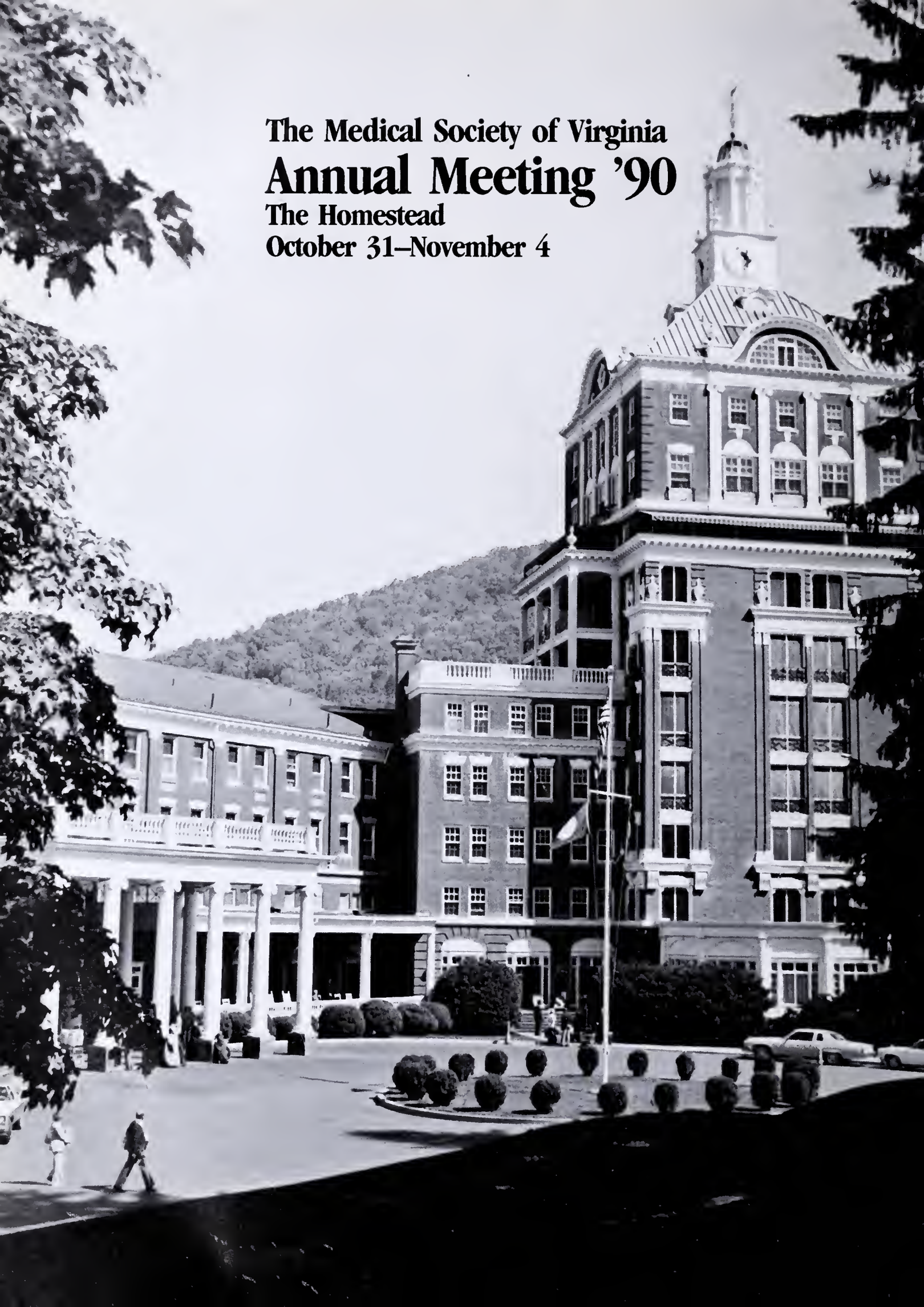
The physician has several options for establishing patient rapport. 1) Orient the front office staff to patient service, activities, and concepts, and teach them how to manage disgruntled patients gracefully. 2) Have information readily available for the patient on the practice, what to do when the office is closed, whom to call and the number. Patients need to understand the rotation of different physicians within a practice and who is available to treat them at different times. To avoid a claim of abandonment, provide patients with written information on partners and coverage arrangements and date when the information was received. 3) Billing practices should be clearly explained on the first visit. Much of this information can be covered by implementing a new-patient orientation procedure.

Systems to monitor, flag and followup patient care focus on tracking the receipt of laboratory and other tests, appointments, complaints, prescription orders and refills, phone messages, and noncompliance with medical regimens. It is equally important to get the information or reports on consultations requested from other physicians. Two wrong diagnoses are easier to defend than one! Use of a matrix record for comparing test results and medication regimens over time is recommended for patients with chronic conditions who are likely to have concomitant medical complications of their primary disease and/or to need consulting physicians.

Coordination and continuity of patient care are facilitated by systems or procedures to assure that the office is adequately covered, that patient problems are discussed and documented, and that patient complaints are resolved satisfactorily. If the commitment is made to cover another physician's practice, then the covering physician is responsible for transferring the information necessary for continuity of care. The primary physician is responsible for establishing and maintaining a mechanism for receiving information and documentation from consulting physicians on hospitalized patients.

Office procedures are a key strategy in preventing claims. Protocols outlining procedures for telephone triage, medication refills, scheduling appointments, performance and receipt of test results, billing and problem accounts, termination of the physician-patient relationship, documentation practices, and patient followup are important components of basic office risk management. Information on how to develop these documents is available from medical societies and some liability carriers.

J.L.N. and B.S.B.



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VIRGINIA MEDICAL

Injured Infant Act

THE Injured Infant Act legislated into law by the 1987 General Assembly of Virginia has been the object of considerable criticism by Virginia physicians. Objections include: the narrow definition of the act; the $5,000 annual fee for participating obstetricians; and the $250 annual fee for all physicians in Virginia.

A portion of the problem has been resolved: The law has been amended to improve the definition of neurologic impairment. However, the other objectionable features persist.

Indeed, the State Corporation Commission audited the present birth injury fund and found it inadequate. An assessment order was issued requiring that the insurance industry be assessed one-tenth of one percent of premiums written in Virginia. Expected revenue for this action is $2.8 million. Currently, the $250 fee paid by physicians contributes $1.8 million annually to the birth-injury fund. And all this is in addition to the assessment levied on participating hospitals: $50 for each delivery, with a maximum of $150,000.

Isn't it about time for participation by the general public?

E.L.K., JR.

Explain

WE PHYSICIANS are constantly told we must take the time and make the effort to explain the medical problem in detail, yet understandably, to the patient. We must educate the patient so that the patient can then make a rational decision about his or her own life. We are constantly reminded that too many physicians rush their explanations, speak in medical jargon, and befuddle rather than inform the patient. We must explain the concept of wellness to our patients.

A properly given explanation will almost always lead a patient to make a proper decision. Defective decision-making by the patient is a reflection upon the physician. You have to tailor the explanation to the patient and the situation.

My aunt was a heavy smoker for 40 years, between one and two packs a day. Her high blood pressure, her family history of cardiovascular disease, the advice of several physicians, and the pleadings of her husband and children had no effect upon her cigarette consumption.

About three years ago she had an episode of bloody urine which led to finding a cancerous bladder tumor. Petrified with fear, she prepared herself for the worst. Fortunately, the tumor was removable by transurethral resection.

As she tells the story, she was just barely awake when her urologist came into the recovery room and told her that she had an excellent prognosis. Futhermore, he strongly advised that she stop smoking to decrease the chances of recurrence of her cancer.

And she has not had a single cigarette, nor the desire for one, since that moment. When asked why she had waited so long to stop smoking when she had been

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cajoled and threatened, begged and urged for years, her response was instructive: "No one ever explained it to me that way before."

H. S. Campell, MD

Lockhart McGuire

Elsewhere in this issue is the memoir of Dr. Lockhart Bemiss McGuire. A professor in the University of Virginia, Department of Medicine, Dr. McGuire was beloved by his patients and admired and respected by his students and coworkers alike. And for good reason: Dr. McGuire was the ideal physician, educator, and citizen. His life was modeled after the words of that hymn: "God be in my head, and in my understanding; God be in my mouth, and in my speaking; God be in my heart, and in my thinking; God be at mine end, and at my departing."[1]

E. L. K., Jr.

1. Hymn 694, Episcopal Hymnbook 1982. Words by Sarum Primer, 1514

Hard Workers

A recent press release from the Virginia Department of Health Professions lists 1,229 complaints recorded by the State's 12 health regulatory boards during the 1989-90 fiscal year. The figure is accurate, but may be misinterpreted. All such complaints are referred to the investigation division, where decision is made as to the validity of the complaint. If the complaint is deemed valid, it is referred for action by the proper board. The actual number of cases received in 1989-90 by the State Board of Medicine totaled 319. Although this is an increase over the 258 complaints in 1985, there does appear to have been a levelling-off of the curve.

During the 1989-90 fiscal year, 340 cases referred to the Board of Medicine were closed. Sixty-four of these were judged to be violations and resulted in sanctions. Eight licenses were revoked, four were suspended, 28 cases resulted in probation and 23 in reprimand. Heading the list were 123 cases involving standards of care. While there were 38 instances of excessive prescribing, it should be noted that in recent years there has been a change in regard to the accepted prescribing of certain drugs; an occasional one of these previously might not have been in violation.

The State Board of Medicine is a hard-working, effective body and one of which the people of Virginia can be justly proud. The Board had functioned well in spite of one major handicap; the present legal system. This is a problem for which there appears to be no solution.

E. L. K., Jr.

GUEST SPEAKER

"Holding to Life Lightly But Not Carelessly"

PEOPLE sometimes talk as if God is capricious about who escapes sudden and untimely death. People do not always question the capriciousness of technology and of our economy in all the business of keeping older people alive or in the use of the resources which might have been used with greater benefits in other ways.

One of my more remarkable experiences was joining, in another city, in a family discussion with doctors regarding the use of exciting and miraculous machinery to add an uncertain number of hours, with even more uncertain meaning, to the life of a brother who had already had a long life of love and service plus a year of courageous suffering. He had spent next to nothing on himself, had a wardrobe chiefly consisting of clothing left by deceased parishioners, and frequently refused salary increases. Here the doctors were, proposing measures without mentioning that they would be costing Medicare and other insurance carriers more per day than my brother would have accepted for a long period of hard work.

It would have been a violation of all he stood for.

No matter how little we like to put a price on the care of the sick, the problem is there and becoming more difficult every day. The longer we refuse to face it the harder it becomes.

All of us resist putting a monetary value on a month's or a year's life, without even considering the capacity of that life for continued meaning in this world. Yet the simplest mathematics make it clear that we cannot go on refusing to face the issues involved. We escape by taking refuge in "the sanctity of life" or by saying it is unworthy to talk about cost in such a situation, yet money is both limited and representative of the love, labor and life of others.

This is a most painful tension—the mysterious value of the spark of life against the mysteries of the world's physical suffering in the midst of plenty. Indeed, there is a certain horror about even raising the questions.

How do we decide when we are respecting the sanctity of life and when we have made an idol of not even a whole life but merely some of the "vital signs?"

Most of us are familiar with the quandary over whether some actions are interventions with natural living or interventions with natural dying. The Richmond Academy of Medicine and the Medical Society of Virginia have promoted a "living will" implementing Virginia's Natural Death Act. I hope each of you has signed one, but there are still many questions about whether the usual form covers enough possibilities. There are also those who point out that a written living will can be limiting by comparison with an understanding developed among members of a family and their doctors. Even then, the trouble is that none of us can decide the way we are going to die, and that brings in the different ways each of us may deal with his own approaching death.

I have always admired the people who have been able to face the approach of death, talk freely with their families about their state of mind and future arrangements (always allowing for the possibility of a reprieve), and yet continue to greet each new day with as much interest and joy as pain will allow.

I suppose I was influenced in these matters by my mother. She paid many visits to hospitals during her last 20 years but always left her bureau in perfect order, with directions for disposal of various items; yet at the same time she lived every day fully. Before her final operation she urged the surgeon to take any chance he wanted to.

I think this is what is meant by holding to life lightly but not carelessly. Yet in this field there remain—and may always remain—terrible questions for which each answer seems to lead to more questions.

We are fortunate that in our day the medical profession is doing its part in *asking* the questions.

JOHN PAGE WILLIAMS, DD

Excerpted from a talk delivered before the Adult Forum at St. Mary's Episcopal Church, Richmond, on March 20, 1988. Dr. Williams was headmaster of St. Christopher's School, Richmond (1940-1951), and then served as Dean of Church Schools in the Diocese of Virginia until his retirement in 1975. Address correspondence to him at 703-G North Hamilton Street, Richmond VA 23221.

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VIRGINIA MEDICAL OBITUARY

• **Albert Facundo Borges, MD,** Falls Church; University of Havana, Cuba, Medical School, 1943; age 70; died May 17, 1990. He had been a plastic/reconstructive surgeon in Falls Church since 1960.

• **Paul Kiser Candler, MD,** retired general practitioner; Medical College of Virginia, 1936; age 83; died June 23 in Virginia Beach. In private practice in Warrenton from 1946, he joined the Salem Veterans Administration Hospital staff in 1964, serving there for ten years.

• **Thomas Frey, MD,** pediatric ophthalmologist in Northern Virginia and a past president of the Virginia Society of Ophthalmology; Northwestern University School of Medicine, 1958; age 56; died July 10, 1990. He conducted practices in Falls Church and Fairfax and lived in Annandale.

• **Conrad L. Gossels, MD,** internist in Washington and Arlington; Friedrich Wilhelm University, Berlin, 1932; age 82; died August 4, 1990. He retired nine years ago.

• **Tibor Ham, Sr., MD,** pulmonary specialist in Vienna, Virginia; University of Tudomanyegyetem, Budapest, Hungary, 1938; age 76; died July 7, 1990. Dr. Ham left Hungary for the United States in 1951 following the Communist takeover.

• **James Arlington Kirkland, Jr., MD,** general practitioner in Emporia; University of Virginia School of Medicine, 1960; age 55; died July 12, 1990. He was mayor of Emporia from 1972 to 1976.

• **Wilmer Howard Paine, Jr., MD,** Charlottesville; University of Virginia School of Medicine, 1930; age 86; died July 20, 1990. He had practiced general medicine in Charlottesville since 1932.

• **Adney K. Sutphin, MD,** retired Richmond internist; Medical College of Virginia, 1941; age 73; died June 4, 1990.

• **Heda Tibor, MD,** Petersburg; Faculté de Medecine de la Université de Lausanne, Switzerland, 1949; age 76; died February 22, 1990.

Memoir of William R. Hill 1908-1990

By James B. Black, MD, Percy Wootton, MD, and Wm. Russell Jones, Jr., MD

Dr. Bill Hill, as he was known to many, was a highly respected general surgeon who practiced in Richmond for 49 years, retiring scarcely two months before he died on 10 April 1990.

Dr. Hill was born 4 October 1908 in Statesville, North Carolina, where he was educated in the public schools. He received his premedical education at Davidson College and his medical degree in 1934 from the University of Virginia School of Medicine, where he also served as chief resident in general surgery.

WILLIAM ROWLAND HILL, MD
1908-1990

Prior to World War II he became associated with Dr. A. L. Herring, Sr., at Grace Hospital in Richmond. He entered the service as a fully trained surgeon and rendered invaluable help to the wounded, serving as major in the Medical Corps with the 8th Evacuation Hospital from the University of Virginia. This hospital served in the North African and Medi-

terranean theaters of operation. After the war he continued his association with Drs. R. C. Siersema and Herring. At the time of his retirement, Dr. Hill was practicing in association with Drs. W. Bruce Stewart, James S. Gregory, Crawford C. Smith, and Jon Palmintier.

Many organizations benefitted at his hand. He was a clinical professor of surgery at the Medical College of Virginia, consultant at the McGuire Veterans Administration Medical Center, and served as president of both the Richmond Academy of Medicine and The Medical Society of Virginia. He was for eight years a member of the State Board of Health and its president in 1979-80.

It would not be possible for me to recall the number of times I have been told of his diligence in visiting patients whom he had once treated but were then situated in another hospital or at home. Such acts of kindness were much appreciated and were performed modestly.

Two days before he died Bill phoned to remind me that a faithful orderly at Grace Hospital had expired and that I should "know about it." His thoughts concerned the welfare of others.

Through the years we often operated together when a patient needed the services of both a general surgeon and a urologist. These occasions were always a pleasant experience, filled with expeditious deliberation and professional good humor. He will be greatly missed from medical practice.

Dr. Hill is survived by his wife, Elizabeth Broaddus Hill of Richmond; two daughters, Sherrard Steele Howen and Beverly Byrd Almond, and one son, John Parrish Hill, all of Charlottesville.

Memoir of Lockhart McGuire 1934-1990

By George B. Craddock, Jr., MD, and John A. Owen, Jr., MD

Sir William Osler paid tribute to those physicians who, he said, "have influenced the profession less by their special work than by exemplifying those graces of life and refinements of heart which make character." Such a man was Lockhart Bemiss McGuire, who died April 29, 1990, at his home, of cancer of the colon.

Born in Richmond on May 8, 1934, he was the son of Dr. Hunter Holmes McGuire and Catharine Bemiss McGuire, and brother to Dr. H. H. McGuire, Jr., of that city. He was educated at Episcopal High School and the University of Virginia, where he received the MD degree in 1957. He was trained in internal medicine and cardiology at the Peter Bent Brigham Hospital and Harvard Medical School. After a tour of duty at the US Naval Hospital, Chelsea, Massachusetts, he returned to the University of Virginia as chief resident in medicine 1963-1964.

Following his appointment to the faculty in cardiology, Dr. McGuire rose rapidly through the ranks to that of professor in 1974. In 1983 he was named the first Julian R. Beckwith Professor of Medicine. He introduced the concept of the Code 12 (resuscitation) team, the Coronary Care Unit, the Pacemaker Clinic, and the use of the Holter monitor to the University of Virginia Hospital. He was active in the American Heart Association and the American College of Cardiology (governor for Virginia 1973-1976). He devoted a great deal of his time to the American College of Physicians, as member of Council for Virginia, as head of the Clinical Efficacy Assessment Program, and as the recipient of the Laureate Award from the Virginia chapter shortly before his death.

He was elected a member of the Raven Society and of Alpha Omega Alpha in medical school, and of the American Clinical and Climatological Society as a faculty member. He won a citation from the dean for excellence in teaching, and was president of the Society of Fellows of the University.

Dr. McGuire was an active member of the Albemarle County Medical Society (president, 1973); of The Medical Society of Virginia, representing the American College of Cardiology at the House of Delegates; and of the Editorial Board of VIRGINIA MEDICAL and the *Virginia Quarterly Review*.

Dr. McGuire cheerfully participated in the Naval

LOCKHART B. MCGUIRE, MD
1934-1990

Photo by John L. Guerrant, MD

Reserve and retired with the rank of Captain, Medical Corps, USNR. He was a former vestry member of St. Paul's Memorial Church in Charlottesville and was a member of the University of Virginia's Center for Clinical Ethics. He is survived by his wife, Anne Kane McGuire of Charlottesville, three children and one grandchild.

He was a loyal friend to colleagues, students, and patients alike. As the ideal physician, educator and citizen, he was a model without equal. To his patients, most of all, he demonstrated skill, devotion, and kindness. He laid less emphasis on the technological advances of cardiology and more on the clinical skills of the meticulous history, the precise comprehensive physical examination and a deep and broad understanding of his patients as individuals grappling with serious problems and needing his kind and patient assistance in decision-making. As he gave of himself to others, he was repaid a thousand-fold by their gratitude, trust, and love.

Shortly before his death, he tried to sum up his life in a typically modest fashion: "Dr. McGuire was the recipient, through previous generations of his family, of a tradition of service in the medical and teaching professions. He worked to repay that legacy in his time. His medical specialty was cardiology, but his loyalty and interest emphasized comprehensive and personal care for the sick."

The late W. B. Bean, in his obituary for Byrd S. Leavell, wrote, "A monument may mark the grave of those whom we ultimately forget, but the goodness and character of a fine physician remain without a carved stone, wrought in the stuff of other mens' lives and deeds." To perpetuate our veneration of the goodness and character of our beloved colleague and friend, the University of Virginia plans to establish an endowed chair, the Lockhart B. McGuire Professorship in Internal Medicine. Contributions to that fund are being sought from colleagues, patients, and friends; they should be earmarked for the Lockhart McGuire Endowed Professorship and mailed to the University of Virginia Medical Alumni Foundation, Box 324, School of Medicine, Charlottesville, Virginia 22908.

News of the death of a Medical Society of Virginia member may appear in these pages in either or both of two ways: 1) a brief notice written by staff giving factual information; 2) a memoir contributed by a physician who knew the deceased peer and writes a personal account of his or her life. If the memoir is contributed before the brief notice is inserted, it is published at once; if after, it is set in type to be published as space permits.

Memoir of C. H. Lippard 1923-1990

By C. H. Sackett, MD, Donald Shotton, MD, G. E. Calvert, MD, and W. H. Barney, MD

Carroll Hoyt (Cullie) Lippard died in Lynchburg, Virginia, on February 13, 1990, at the age of 66. Dr. Lippard was born in Statesville, North Carolina, and was educated in the public schools of North Carolina, receiving his undergraduate degree at the University of North Carolina. He was awarded his MD degree from the University of Pennsylvania in 1947 and had his internship and residency training in obstetrics and gynecology at the University of Pennsylvania, his time there being interrupted by United States Naval Service in the Panama Canal Zone.

CARROLL H. LIPPARD, MD
1923-1990

Dr. Lippard began his practice of obstetrics and gynecology in 1953 and continued until his retirement in 1988. He was a member and past president of the Lynchburg Academy of Medicine. He was also a member of the Medical Society of Virginia, the American Medical Association, the Southern Medical Association, the Virginia Ob-Gyn Society, the Southeastern Ob-Gyn Society, and the South Atlantic Association of Obstetricians and Gynecologists, serving as president of that group in 1978-79.

In 1975, Dr. Lippard was appointed by Gov. Mills E. Godwin to the State Board of Medical Examiners,

where he served with distinction until 1983, and was Board president from 1980-1982.

In addition to his medical interest, he had an outstanding concern for civic affairs. He was president of Friends of the Lynchburg Public Library, and his involvement led to the present library in 1967. In 1967-68, Dr. Lippard organized and was chairman of the Central Virginia Asian Affairs Committee, and for this work he received the Law Day Award from the Lynchburg Bar Association in 1968. Also in 1968, Dr. Lippard was elected to the Lynchburg City Council and served as vice-mayor of Lynchburg from 1970-72. He was the organizing chairman of the Lynchburg Bicentennial Commission.

Dr. Lippard's sports love was tennis, at which he excelled, and he was the first president of the Lynchburg Tennis Patrons Association. He was a life-long Lutheran and was active in Holy Trinity Lutheran Church, serving in many capacities, including president of the Church Council. He was also an accomplished musician, played the piano and sang in the Holy Trinity Church Choir for 35 years.

Dr. Lippard is survived by his wife, Sally Ford Lippard, and four children, Leslie Lippard Brown Hawes, Ann Lippard Drescher, Margaret Kimball Lippard, and Robert Carroll Lippard; and grandchildren, Megan, Molly Kate, and Matthew Brown; Cullen, John Brent and Christopher Corbin Drescher; and Brittany Gray and Robert Lippard.

Dr. Lippard was highly respected by his colleagues and his patients, and tributes following his death came from many walks of life. The Lynchburg newspaper editorialized that "from city library to City Hall to hospital delivery room, the memory of Dr. Carroll H. Lippard lingers as a kind man who believed in the innate goodness of people."

Colleagues reported that he brought a touch of class and gentility to everything he did, that he had an excellent mind, was a real scholar and a student of history and philosophy. One colleague described him as a "thoroughbred" and stated that "all people looked alike to him."

Cullie delivered more than 12,000 babies in his career and continued deliveries until the week before he retired.

Cullie's death is a loss to Lynchburg and to the medical profession, but both are better for his having passed this way.

Memoir of Ralph R. Landes 1911-1989

By B. R. Ashby, MD

Ralph R. Landes, MD, who founded the Danville Urologic Clinic and was the senior partner until his retirement in 1985, died October 5, 1989, in Chicago.

A native of Milwaukee, Wisconsin, Dr. Landes graduated from the University of Wisconsin and received his MD from Rush Medical College of the University of Chicago in 1939. He served his internship at Michael Reese Hospital and did his surgery and urology training there and at Boston City Hospital. During World War II he served as a medical officer with the 16th Evacuation Hospital in Africa and Italy and after discharge joined the medical staff of the Martinsville, West Virginia, Veterans Administration Hospital. In 1949 he moved to Danville to begin his private practice of urology.

Dr. Landes was president in 1960 of the medical staff at Danville's Memorial Hospital, and had served also as the hospital's chief of surgery (1965-1967) and urology (1960-1976). The library at the hospital was named the Ralph R. Landes Medical Library in his honor after his retirement. At the University of North Carolina, where he served as clinical professor of urology, his colleagues and former residents established the Ralph R. Landes Annual Lectureship. He also was a lecturer in medical history at the Bowman Gray School of Medicine of Wake Forest University. He was the author of more than 150 published articles and frequently presented papers at scientific meetings in this country and abroad.

He was president in 1968 of the Danville-Pittsylvania Academy of Medicine and in 1960 of the Virginia Urological Society. From 1965 to 1979 he served as historian of the American Urological Association. A fellow of the American College of Surgeons, he belonged also to the Medical Society of Virginia, American Medical Association, American Association of Clinical Urologists, American Academy of Pediatrics (urological fellow), the Society for Pediatric Urology, the Southern Medical Association, and the Societé Internationale d'Urologie.

He was very active in community affairs and was on the board of trustees of Averett College in Danville, the Wayles Harrison Cancer Foundation, and the Science Museum of Virginia in Richmond. He was a member of the Church of the Epiphany in Danville.

He lived his retirement years in Danville, Chicago, and the mountains of Virginia in Monterey, where he was interred.

He is survived by his devoted wife, Elizabeth Lightner Landes, of Chicago and Monterey; a son, John L. Landes of Nashville, Tennessee; and, a daughter, Elizabeth M. Landes Levanstam, of Chicago.

Physician, scholar, historian, teacher, researcher,

colleague, humanitarian, husband, father, friend—Dr. Ralph R. Landes was the perfect example of "a man of all seasons," whose memory will long endure in the hearts of all who were privileged to know him.

Memoir of Harold Bassham 1936-1990

By J. Thomas Hulvey, MD

Dr. Harold Lee Bassham, age 54, died at Johnston Memorial Hospital in Abingdon, Virginia, on May 17, 1990, following a brief illness. He was the senior radiologist at Johnston Memorial, having entered private practice there in April 1971.

Dr. Bassham graduated from Centenary College in 1956. He received his degree in medicine from Louisiana State University School of Medicine in 1960. He interned at the U.S. Naval Hospital in Portsmouth, Virginia, from 1960-61, then entered the navy nuclear power and submarine medicine training program, which he completed in 1962. He served in the U.S. Naval Submarine Force, Atlantic, until 1964 and was a member of the commissioning team of the nuclear submarine U.S.S. James Monroe. He received his residency training in radiology at the U.S. Naval Hospital, Oakland, California, the University of California at San Francisco, the Armed Forces Institute of Pathology, and the National Naval Medical Center, Bethesda, Maryland, completing his residency in 1967. He was a veteran of the Vietnam War, serving as chief of radiology aboard the U.S.S. Repose.

He was a diplomate of the American Board of Radiology and a fellow of the American College of Radiology and the Radiological Society of North America. He belonged to The Medical Society of Virginia, Southwestern Virginia Medical Society, and the Washington County Medical Society.

Lee was an exceptional radiologist and a cherished member of his hospital staff. He was a thoughtful, caring man who gave freely of his time and his many talents to those who sought his counsel. He was a devoted churchman, having served on the vestry of St. Thomas Episcopal Church, and he had worked with the Boy Scouts.

He is survived by his wife, Joyce; his sons, Randy, Steve, Mark and Phillip; his parents; and a sister. He will be remembered with a great sense of loss by his friends and colleagues.

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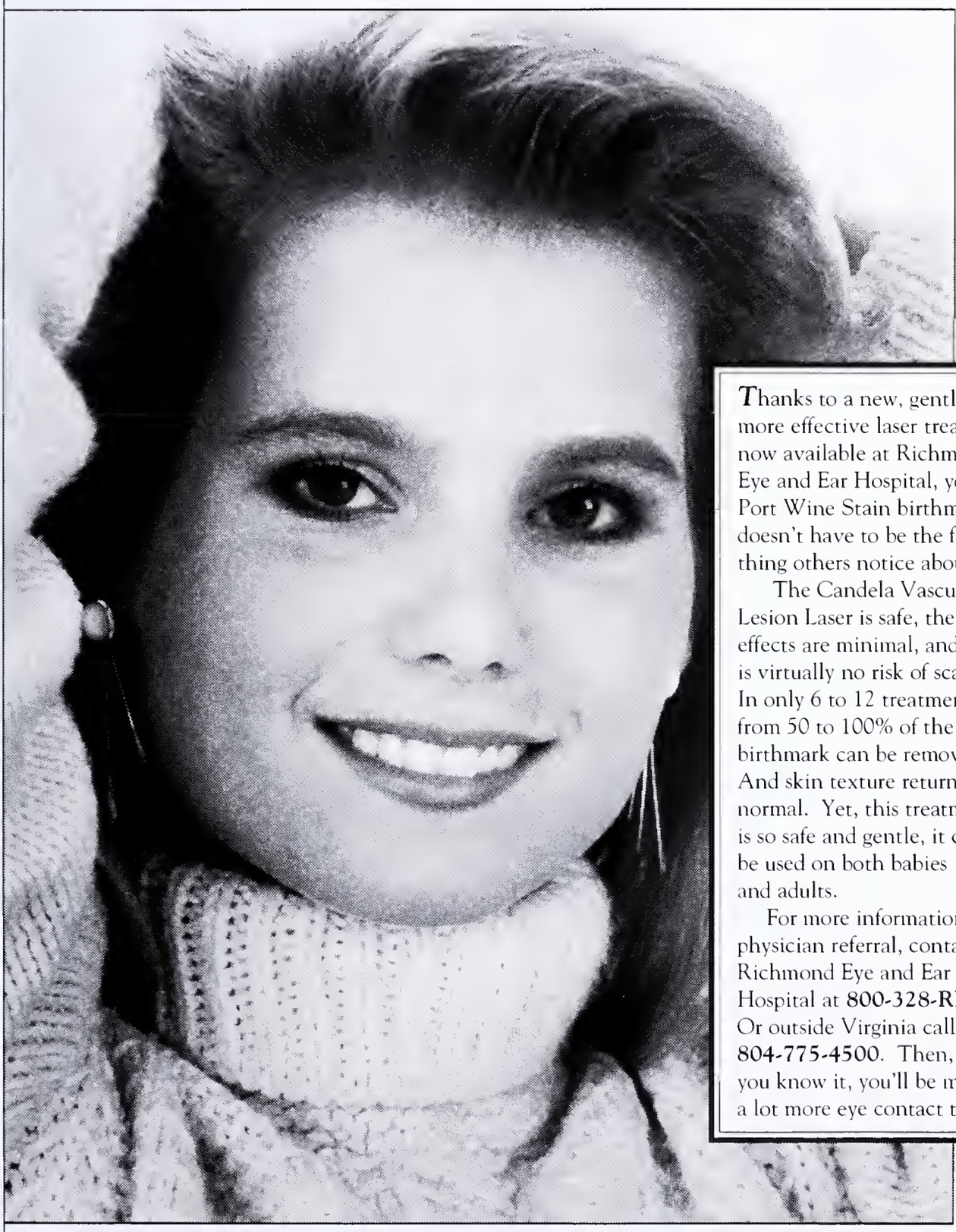

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- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
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- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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BOOKS

Colonel Parke of Virginia: "The Greatest Hector in the Town," by Helen Hill Miller. Chapel Hill, North Carolina, Algonquin Books of Chapel Hill, 1990, 232 pages, illustrations, $19.95 cloth.

For those of us in Virginia, it is always interesting to read of the major and minor characters forging the origins of our great country, starting with England's first permanent colony in America. Such a person was Daniel Parke, Jr., part-time roué, part-time adventurer, but always on top of things until he met his end in the Leeward Islands of the Caribbean at the hands of the islanders enraged at his adulterous ways.

This man managed to be the one to bring the news of the tremendous victory of John Churchill, Duke of Marlborough, and his combined forces from England, Holland and Germany against the combined armies of France and Bavaria. Parke delivered the news personally to Queen Anne and, for his labors, was given a diamond-encrusted gold locket. Parke put together, largely by inheritance, the single largest estate in York County, Virginia. This gave him entreé into Virginia politics with an eventual seat on the Governor's Council, but never the governorship to which he aspired. His corrupt ways hampered him in Virginia as well as England, where he sought a seat in the House of Commons.

Failing to get the Royal Governor's appointment to Virginia, Parke turned to the Caribbean Islands; the future seemed bright there for England as the power of Spain declined. Here again Parke lost it all by his corrupt and immoral ways. He was Royal Governor of the Leeward Islands in the West Indies when he met his end.

Mrs. Miller is authoritative without being pedantic and focuses on data she has meticulously gathered into a decision tree and the issues are well addressed.

Daniel Parke, Jr.
From *Colonel Parke of Virginia*

The author describes a quidnunc of the times, with an eerie sense of dejà vu, as this rake goes from one adventure to another, seemingly caring not at all what he does to others to achieve his ends. His flawed character and eccentricities are clearly brought out by Mrs. Miller. The extensive research done by this remarkable writer, who was in her 91st year when this book was written, is a paradigm of critical social insights and analyses of seventeenth century doings which had such an impact on Virginia and its early development.

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MEETINGS

October 31
Risk Management and Medical Insurers (Medical Society of Virginia/Virginia Insurance Reciprocal/Medical Protective), the Homestead, *Hot Springs*. 4 credit hrs. Mrs. Evelyn Stockmar at MSV headquarters, 804-353-2721.

November 1-4
5th Annual Advances and Controversies in Internal Medicine Seminar (Lloyd Noland Hospital), the Greenbrier, *White Sulphur Springs, West Virginia*. Dr. George M. Converse, 205-783-5276 or -5121.

November 1-4
Principles and Practice of MRI (Johns Hopkins), *Baltimore*. 24 credit hrs. Fee: $495. CME Office, 301-955-2959.

November 3
A Day on Foot, a Symposium on Foot Disorders (National Hospital for Orthopaedics/Rehabilitation), *Arlington*. Leslie Gilliam, 703-920-6700.

November 3-4
Hemodynamic Monitoring, Patient Care and Pulmonary Artery Catheterization (Johns Hopkins), *Baltimore*. 14 credit hrs. Fee: $425. CME Office, 301-955-2959.

November 5
Advanced Pediatric Life Support Course (Johns Hopkins), *Baltimore*. 20 credit hrs. Fee: $495. CME Office, 301-955-2959.

November 10
Managed Care: 1990s and Beyond (Eastern Virginia Medical School), *Virginia Beach*. 5 credit hrs. Fee: $25. CME Office, 804-446-6140.

November 11-15
13th Edition, Practical Dermatology for the Primary Care Physician (Eastern Virginia Medical School), *San Diego, California*. 22 credit hrs. Fee: $425. CME Office, 804-446-6140.

November 12-15
Primary Care Update (Interstate Postgraduate Medical Association), Walt Disney World Village, *Lake Buena Vista, Florida*. IPMA, 608-257-1401.

Continued on page 395.

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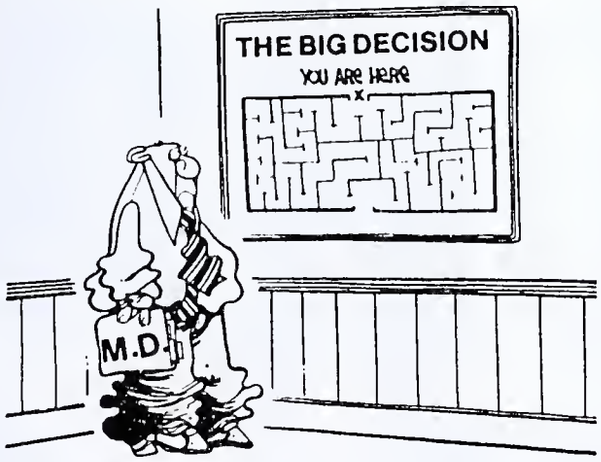

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November 29-December 3
16th Annual Assembly Meeting, Hospital Medical Staff Section, American Medical Association, *Orlando, Florida*. 312-464-4754 or -4761.

December 7-8
7th Annual Virginia Impaired Health Professionals Conference (MSV Physicians' Health/Effectiveness Committee), *Williamsburg*. Jeanne Douglas, 804-353-2721.

January 24-26
25th Annual Meeting of the Neurosurgical Society of the Virginias, the Greenbrier, *White Sulphur Springs, West Virginia*. Dr. George Johnson, 804-320-2758.

January 27-February 1
Gastroenterology Update 1991 (Johns Hopkins/American College of Gastroenterology), *Aspen/Snowmass, Colorado*. 20 credit hrs. Fee: $450. CME Office, 301-955-2959.

February 1-3
Annual Meeting of the Virginia Neurological Society, the Homestead, *Hot Springs*. Donna Scott, 804-353-2721.

February 28-March 3
Principles and Practice of Clinical MRI (Johns Hopkins), Walt Disney World Village, *Lake Buena Vista, Florida*. 20 credit hrs. Fee: $495. CME Office, 301-955-2959.

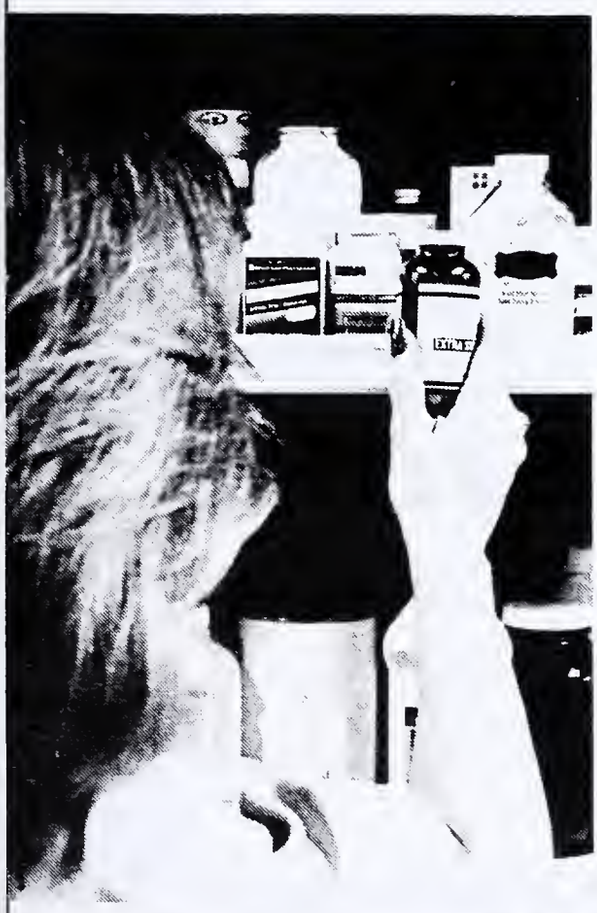
February 10-14
1991 Scientific Assembly of the Virginia Chapter, American College of Emergency Physicians, the Homestead, *Hot Springs*. 18 credit hrs. Gwen Messler Harry, 804-966-5966.

February 23-March 2
5th Annual Current Innovations in the Practice of Gastroenterology, (Georgetown University), *Snowmass Village, Colorado*. CME Office, 202-687-8735.

March 1-3
Virginia Pediatric Conference '91: Annual Meeting of the Virginia Chapter, American Academy of Pediatrics and the Virginia Pediatric Society, Boar's Head Inn, *Charlottesville*. 804-643-8130.

May 3-5
Annual Meeting of the Virginia Surgical Society, *Williamsburg*. Irving L. Kron, MD, 804-924-2158.

May 9-12
Annual Meeting of the Virginia Chapter, American College of Radiology, *Williamsburg*. Patricia R. Berry, 703-669-8312.



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Eric R. Powers, MD, Cardiology, Box 158-22, University of Virginia Health Sciences Center, Charlottesville VA 22908

Frederic B. Westervelt, MD, Nephrology, Box 133, University of Virginia Health Sciences Center, Charlottesville VA 22908

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Wayne D. Old, MD, Cardiology, 1321 Smith Cove Circle, Virginia Beach VA 23455

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continued on page 398

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PS Form 3526, Feb 1989 *(See instructions on reverse)*

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LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function, resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

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L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for anorectic effects.

PRECAUTIONS:
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Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear.

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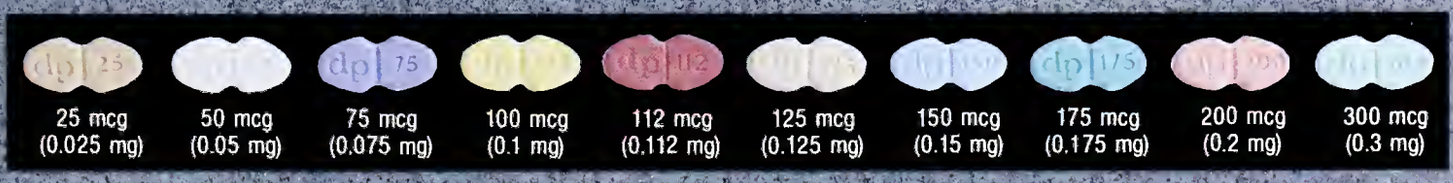

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WHO'S WHO

Dr. Percy Wootton of Virginia moved into the national spotlight at the American Medical Association's recent annual meeting in Chicago when he served as chairman of one of the meeting's three reference committees. Well schooled in the art of presiding, the Richmond cardiologist is a past president of the Medical Society of Virginia and current chairman of the Society's AMA delegation. For the AMA, he is a member of the Council on Legislation and has announced his candidacy, in the 1991 election, for the AMA Board of Trustees.

Dr. Raymond S. Brown has retired from his Gloucester Court House family practice. Plagued by severe arthritis and depleted by over 40 years of practicing solo, he feels the need, he says, to spend a lot of time in a rocking chair on the porch of his home in Zanoni. From Zanoni he can see the house where he was born. "I was born and raised and worked and will be buried within a 5-mile radius," he observes.

A graduate of the Medical College of Virginia, Dr. Brown spent three years in the Navy before starting up his practice in Gloucester. The minute his practice began, so, too, did his commitment to community service, and in 1977 the Medical Society of Virginia gave him its highest honor, the A. H. Robins Award for Community Service. Cited were his leadership roles in the Gloucester Rotary and Lions Clubs, the Ware Episcopal Church Men's Club, Virginia Tuberculosis Association, local chapter of the Red Cross, Gloucester Library Fund, and the F. N. Sanders Nursing Home. He has been president of the Mid-Tidewater Medical Society, the Hampton Roads Academy of Family Practice, and the Medical Society of Virginia, and is currently a member of the Virginia delegation to the AMA and this journal's Editorial Board.

After a two-year search, Dr. Brown found a successor in Chicago. He is Dr. Mark Shawnik, who moved his wife and three children to Virginia's Northern Neck and took over the practice early in August.

New president of the Seaboard Medical Association is **Dr. Roger T. Gregory,** Norfolk cardiovascular surgeon. Other Virginians elected to office with him are **Dr. Alvin J. Ciccone,** Norfolk, second vice president, and **Dr. Ronald K. Davis,** Richmond, fourth vice president.

Dr. Frank S. Blanton, Jr., Bristol, was elected president of the Virginia Chapter, American College of Surgeons, during the chapter's annual meeting in Norfolk.

A Richmond surgeon, **Dr. Wyatt S. Beazley III,** heads the Virginia Surgical Society as president for 1990-91. His election occurred at the society's annual meeting in Hot Springs.

Virginia anesthesiologists have elected as their new president **Dr. William P. Arnold III,** of the University of Virginia School of Medicine, Charlottesville.

When Eastern Virginia Medical School's Faculty Achievement Awards for 1990 were handed out, two of the five winners were physicians. They are **Dr. David B. Propert,** professor of internal medicine, whose award was for achievement in teaching in the clinical sciences, and **Dr. Claiborne W. Fitchett,** professor of surgery, whose award honored achievement by community faculty.

The names of two Medical Society of Virginia members showed up among Gov. L. Douglas Wilder's appointments: **Dr. David W. Branch,** Roanoke, was appointed a member of the State Board of Medicine, and **Dr. C. M. Kinloch Nelson,** Richmond, was reappointed a member of the board of directors of the Virginia Birth-Related Neurological Injury Compensation Program.

Across the Bay from Gloucester, on Virginia's Eastern Shore, **Dr. Walter A. Eskridge** couldn't give his practice away when he retired.

"A few people came to look it over," he related, "and one even kept coming back over a period of

Dr. Wootton

Dr. Brown

three or four weeks, but he finally decided against it." So Dr. Eskridge closed his office in Parksley, sold the equipment, and set about sorting/storing a four-decade accumulation of medical records. Parksley had no doctor when he set up practice there in 1952 and now has none again.

Born and reared in West Virginia, Dr. Eskridge took his MD degree and also interned at the Medical College of Virginia. His training complete, he looked for a place "where they really needed a doctor," and found it in Parksley. By the time he retired **Dr. Parker C. Dooley,** Eastern Shore internist, commented to reporter Nancy Namoski of the *Eastern Shore News* that "we would need three or four doctors to replace Dr. Eskridge. I don't know if anyone is willing to work that hard."

In addition to his clinical case load, Dr. Eskridge served as mayor of Parksley and was for many years the Accomack County medical examiner and the physician for the Accomack County Nursing Home. He was a member of the Virginia State Board of Medicine 1973–78, has held all available offices, including the presidency, of the Accomack County Medical Society, and this year for the umpteenth time will be a delegate to the Medical Society of Virginia's annual meeting.

The Accomack County Board of Supervisors honored his retirement by giving him a plaque of appreciation and a standing ovation, and the townsfolk turned out for "Walter Eskridge Day in the Park."

Dr. Charles H. Robertson, Jr., Richmond pulmonary specialist is the new president of the American Lung Association of Virginia.

In ceremonies at the AMA National Congress on Adolescent Health in Chicago, **Dr. Richard H. Schwartz** of Vienna, Virginia, received an award for distinguished service on behalf of America's youth. Dr. Schwartz "combines the private practice of pediatrics with a dedication to teaching and the prevention of drug and alcohol abuse,"

Dr. Eskridge

said the Adolescent Health award citation, and "has distinguished himself in service to youth." A member of the American Academy of Pediatric's Task Force on Substance Abuse, Dr. Schwartz was the 1989 recipient of the Academy's Practitioner Research Award.

As president of the Historical Society of Mecklenburg County, **Dr. William A. Shelton** is heading up the restoration of "Elm Hill," an 18th century estate occupying an important role in the Southside county's history. Built in the mid-1700s by a Prince George County merchant, Elm Hill became the home of Sir Peyton Skipwith in the 1760s and stayed in the Skipwith family until 1865. The Association for the Preservation of Virginia Antiquities came into possession of it in 1982 and turned the deed over to the Mecklenburg society in 1988.

Three Medical Society of Virginia members were among the 118 physicians inducted as fellows of the American College of Critical Care Medicine at its meeting in San Francisco. They are **Dr. L. Delano Britt,** Norfolk; **Dr. Russell P. Seneca,** Annandale; and **Dr. John D. Ward,** Richmond.

Under construction in Norfolk is a new $12.5 million facility to house the institute founded by **Drs. Howard and Georgeanna Jones,** whose work in reproductive medicine at Eastern Virginia Medical School is known 'round the world. Currently, clinical and research operations for the Jones Institute are located on separate campuses; the new 60,000-sq-ft, 4-story building will join them under one roof.

Dr. Morton P. Chiles, Culpeper, was named 1990 Physician of the Year at Culpeper Memorial Hospital for "special contributions to the community and to health care," said the hospital president, Bill Gravely, in conferring the award. "He has balanced his volunteer responsibilities with his medical practice in an exemplary way." Dr. Chiles is a member of the Culpeper County School Board and participates in a youth group at his church.

The Virginia Academy of Family Practice has named **Dr. James B. Harris** of Blackstone its Family Physician of the Year. The honor was bestowed at the Academy's annual meeting in Virginia Beach. A practicing family physician since 1960, Dr. Harris is well-known to Virginia's medical community for his leadership role in the Blackstone Family Practice Residency Program, through which 100 young doctors have been trained. He is a big man in the Blackstone community, too—the town's mayor since 1982 and president of the Blackstone Rotary Club.

The nation's veterans' hospitals have a new medical director. He is **Dr. James W. Holsinger, Jr.,** cardiologist, who was director of the McGuire Veterans Administration Medical Center in Richmond from 1981 until he departed to Washington. **Dr. John T. Farrar,** chief of staff at the Richmond VA Hospital for 11 years, was appointed Dr. Holsinger's associate deputy.

Photo of Dr. Wootton, Joe Fletcher for the AMA; Dr. Brown, courtesy the *Newport News Daily Press*; Dr. Eskridge, courtesy the *Eastern Shore News*.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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